

**Informed Choice, Not Informed Consent: Towards a  
meaningful consideration of pre-treatment advice**

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## Abstract

Healthcare professionals, legal professionals, patients, scholars and members of Research Ethics Committees all hear the term 'informed consent' and seem to assume a common meaning. It is a phrase often said and widely accepted, but what does it really mean? This thesis challenges the doctrine of 'informed consent' and argues that it lacks coherence and fails in its foundational goal: to protect the autonomous patient. It argues that 'informed consent' is a misnomer; that the process under consideration is not about the consent to treatment, rather it is about individual choice.

This thesis critically examines the evolution of the doctrine of 'informed consent' across three jurisdictions (the United States, the United Kingdom and Australia) and focuses on the central debates. These include the appropriate measure for standard of care and the nature of the test for causation. It asserts that these ongoing issues mask the true dilemma facing the Courts which is the problematic nature of linking a dignitary harm (the denial of complete information) with a logically irrelevant physical harm (the manifestation of a physical risk inherent in the treatment).

The thesis departs from existing literature on 'informed consent' by challenging the relevance of the term 'consent' and proposing the adoption of choice. The proposed model of choice emerges from the critical analysis of the law and the existing body of scholarly literature. These both demonstrate an ongoing struggle with the ability of the existing doctrine to achieve the core aim of protection of autonomy. Central to this proposal is the adoption of a narrow, purposive definition of autonomy which is based upon the ideal of narrative autonomy. Under this model the individual is identified as a storyteller, in control of their own narrative path. Crucial to this ideal is the provision of information regarding possible future selves, and it is here that the key concepts of autonomy and choice under the proposed model of 'informed choice' meet.

The thesis concludes by drawing these two themes together and demonstrating that clarity can only be found by retreating from 'informed consent' and adopting a legal ideal of 'informed choice'.

I, Bernadette Richards, certify that this work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

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Signed (B.J.Richards)

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Date

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## Chapter 1: Introduction

*'A phrase begins life as a literary expression; its felicity leads to its lazy repetition: and repetition soon establishes it as a legal formula indiscriminately used to express different and sometimes contradictory ideas.'*<sup>1</sup>

### What is informed consent?

[1.10] Healthcare professionals, legal professionals, patients, scholars and members of Research Ethics Committees all hear the term 'informed consent' and seem to assume a common meaning. It is a phrase often said and widely accepted, but what does it really mean? Is it a concept that is clearly defined and protected at law or is it an example of the way that 'uncritical use of words bedevils the law'?<sup>2</sup> This thesis will challenge the doctrine of 'informed consent' and argue that it lacks coherence and fails in its foundational goal to protect the autonomous patient. It will present an alternative view and argue that 'informed consent' is a misnomer; that the process under consideration is not about the consent to treatment, rather it is about individual choice.

The adoption of the term choice in my thesis is critical to the central argument. It is not a casual decision and reflects the language of the High Court in the seminal case of *Rogers v Whitaker*.<sup>3</sup> In *Rogers*, the Court referred to the fact that a choice to undergo treatment is 'meaningless' if it is made on the basis of incomplete information.<sup>4</sup> Importantly, once a patient has agreed in broad terms to undergo treatment, they have satisfied the basic consent requirement: they have negated any battery action. However, if they make a choice to undergo the treatment in the absence of complete information, that choice can be described as meaningless. It could be said that it lacks content.

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<sup>1</sup> *Tiller v Atlantic Coast Line Railroad Co* 318 US 54 (1943), 68 Frankfurter J.

<sup>2</sup> *Ibid.* In this instance Frankfurter J was referring to the phrase „assumption of risk.“

<sup>3</sup> (1992) 175 CLR 479.

<sup>4</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

To make a meaningful choice, individuals need to be aware of all of the significant options. It is this process of information exchange that is the starting point of the current doctrine of 'informed consent' but the discussion becomes diverted once the issue of consent to treatment is introduced. Returning now to the doctrine as it currently stands we see that at its simplest, 'informed consent' is shorthand for a process of consenting to medical treatment.<sup>5</sup> According to the doctrine<sup>6</sup> of 'informed consent,' any decision to undergo medical treatment must be based upon the provision of sufficient information. As a term, 'informed consent' is commonly used in the academic literature, judicial decisions and by healthcare professionals to refer to pre-treatment conversations. Informed consent is interpreted as a procedure to be followed, something that a treating doctor does to the patient. It is an activity that happens prior to the administration of medical treatment: something that the patient gives to the treating doctor in exchange for treatment.

## **The scholarly landscape of informed consent**

[1.20] Informed consent has been the source of active scholarly debate for at least thirty years. The inconsistency and variability of the application of the doctrine was raised by Devereux in 'It's Just a Jump to the Left - and then a Step to the Right,'<sup>7</sup> and Skene hinted at similar concerns with references to 'swings, roundabouts and pendulums.'<sup>8</sup> Others have referred to the

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<sup>5</sup> It is also used to connote consent to participation in research activities but in the context of this thesis, the discussion is limited to consent to medical treatment.

<sup>6</sup> Informed consent is variously described as a doctrine, term, phrase, test and concept throughout this thesis. These descriptions are used interchangeably, for the most part this is for elegant variation but when I am describing the „doctrine“ of informed consent I am referring specifically to the legal test as developed by the Courts.

<sup>7</sup> J. Devereux, „It's Just a Jump to the Left - and then a Step to the Right: Developments post *Rogers v Whitaker* in the Law Relating to Failure by a Medical Practitioner to Advise of Risks“ (1998) 17 *University of Tasmania Law Review* 63.

<sup>8</sup> L. Skene, „Doctors' Duty to Inform: Debates pre-and post *Rogers v Whitaker*: Swings, Roundabouts and Pendulums,“ (2002) 11(3) *Australian Health Law Bulletin* 33.

'debunking of myths and misconceptions'<sup>9</sup> and described the ideal of 'informed consent' as being 'mythical' or 'fairytale-like.'<sup>10</sup> The intersection of law and morality was raised by Boos and Boos<sup>11</sup> and Montrose asked whether negligence and informed consent are creatures of ethics or sociology.<sup>12</sup> The overwhelming scholarly mood is thus one of caution and scepticism, and as summed up by Smith, the debate serves to highlight the 'vagaries of informed consent.'<sup>13</sup>

The 1990s saw a flurry of scholarly activity when the Australian High Court made what was deemed a significant departure from the accepted approach to the question of professional standard of care in the provision of pre-treatment advice (as enunciated in *Bolam v Friern Hospital Management Committee (Bolam)*).<sup>14</sup> The influential decision of *Rogers v Whitaker*<sup>15</sup> saw the High Court turning away from the previously accepted *Bolam* standard and apparently refocus the debate on the central character of the patient. It was forecast that this decision would lead to greater uncertainty and an increase in claims.<sup>16</sup> *Rogers v Whitaker* apparently caused some alarm amongst the medical profession<sup>17</sup> and resulted in the spilling of 'remarkable amounts of ink and angst' about potential ramifications.<sup>18</sup>

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<sup>9</sup> J.M. Beck and Elizabeth Azari, „FDA Off-Label Use, and Informed Consent: Debunking Myths and Misconceptions“ (1998) 53 *Food and Drug Law Journal* 71.

<sup>10</sup> J. Katz „Informed Consent – A Fairy Tale?“ (1977) 39 *University of Pittsburgh Law Review* 137 and then the later lament, J. Katz „Informed Consent – Must it Remain a Fairytale?“ (1994) 10 *Journal of Contemporary Health Law and Policy* 69. See also M. Jones „Informed Consent and Other Fairy Stories,“ (1999) 7 *Medical Law Review* 103.

<sup>11</sup> K. Boos and E. Boos, „At the Intersecton of Law and Morality: A Descriptive Sociology of the Effectiveness of Informed Consent Law,“ (2004) 5 *Journal of Law in Society* 457.

<sup>12</sup> J.L. Montrose, „Is Negligence an Ethical or Sociological Concept?“ (1958) 21 *Modern Law Review* 259.

<sup>13</sup> G. Smith, „The Vagaries of Informed Consent“ (2004) 1 *Indiana Health Law Review* 111.

<sup>14</sup> [1957] 1 WLR 582.

<sup>15</sup> (1992) 175 CLR 479.

<sup>16</sup> D. Newnes and G. Pynt, „Failure of Surgeon to Advise Patient of Risk of Sympathetic Ophthalmia“ (1993) *International Insurance Law Review* 81.

<sup>17</sup> F.A. Trindade, „Disclosure of Risks in Proposed Medical Treatment“ (1993) 109 *Law Quarterly Review* 352, 354.

<sup>18</sup> I. Freckelton, „*Rogers v Whitaker* Reconsidered“ (2001) 9 *Journal of Law and Medicine* 5, 10. The decision has continued to attract debate and was deemed significant enough to warrant a conference to mark its 10 year anniversary: „conference convened to recognise the tenth anniversary of the decision, AIHLE Conference: Informed Consent in Australia - Tenth Anniversary of *Rogers v Whitaker* held at ANU 26 October 2002.“

## Locating my thesis in the scholarly landscape

[1.30] The focus of the scholarly literature tends to be on the actual duty itself and, of course, the test for standard of care. There is also the related debate as to whether or not the term ‘informed consent’ is appropriate, or even a part of the law. In these discussions, autonomy is raised and accorded due deference, the nature of the causation enquiry is acknowledged, but there is little concern with the true nature of the loss. There is a level of deference paid to the consent process, but there is little in depth analysis of what happens after that.

The reality is that the incongruity of measuring a loss of personal autonomy by an unrelated physical harm is yet to be consistently raised in the academic and judicial discussions, and it is this incongruity which sits at the heart of my thesis. It has been asserted that ‘informed consent has come to obscure rather than to clarify the goal it was designed to serve.’<sup>19</sup> This thesis will return to the original goal of the doctrine of informed consent and challenge the inclusion of the trespassory concept of consent. Instead of consent, I will, as introduced above, focus on the process of choice and establish a new model of loss (and therefore damage). This proposed model will, unlike consent, serve to protect and recognise the dignitary harm suffered by a patient when they agree to undergo treatment without being provided with all material information.

The scholarly debates regarding ‘informed consent; have been many and varied. To effectively locate my discussion in the scholarly landscape it is appropriate to begin with a snapshot of the discussions of others. It would be impossible here to provide a complete overview so I have chosen two eminent

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<sup>19</sup> Joseph Goldstein, „For Harold Lasswell: Some Reflections on Human Dignity, Entrapment, Informed Consent and the Plea Bargain” (1974-5) 84 *Yale Law Journal* 683, 690.

scholars (Jay Katz <sup>20</sup> and Sheila McLean<sup>21</sup>) whose work has spanned three decades. I have chosen these two scholars because they are highly regarded and their work spans a significant period of time. Whilst neither is Australian they are both relevant to the law in this jurisdiction. The doctrine of informed consent as it has developed here is nestled somewhere between that of the United Kingdom and the United States. Indeed the doctrine here has relied heavily on comparative discussions of these two jurisdictions and purportedly marks departures from the accepted law in both.

Both Katz and McLean have re-visited the 'informed consent' debate in different guises, developing sophisticated arguments and concerns about the existence of the doctrine and raising questions regarding the nature of the interest that is protected by informed consent. If we briefly consider their core arguments we will gain some insight into the broader debates.

As early as 1977 Katz questioned the reality of a doctrine of informed consent in his article, 'Informed Consent - A Fairy Tale?'<sup>22</sup> Here he described informed consent as 'symbolised by conflicting interests' and suggested that it is this conflict which has shaped the doctrine.<sup>23</sup> In Katz's view, the leading United States decision of *Canterbury*<sup>24</sup> represented an 'apparently bold move' but lamentably, introduced a test that was 'far from clear'.<sup>25</sup> Of interest here is his assertion that the judicial focus was on disclosure to the exclusion of

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<sup>20</sup> „Informed Consent – A Fairy Tale?“ (1977) 39 *University of Pittsburgh Law Review* 137 and J. Katz „Informed Consent – Must it Remain a Fairytale?“ (1994) 10 *Journal of Contemporary Health Law and Policy* 69 he also published a book in 1984 *The Silent World of Doctor and Patient* The Free Press, (New York, 1984) which was deemed sufficiently current and relevant to warrant a re-publication with a new foreword by Alexander Morgan Capron in 2002 (Baltimore, Johns Hopkins University Press).

<sup>21</sup> Sheila A.M McLean, *A patient's right to know: Information disclosure, the doctor and the law* (Dartmouth Publishing company, Aldershot, 1989) and more recently *Autonomy, Consent and the Law* (Routledge-Cavendish, London, 2010).

<sup>22</sup> (1977) 39 *University of Pittsburgh Law Review* 137.

<sup>23</sup> *Ibid*, 155.

<sup>24</sup> *Canterbury v Spence* 464 F. 2d 772 (1972). Of relevance to this discussion as it is popularly viewed as representing the United States position of a patient centred doctrine of informed consent. The decision is discussed in some detail in Chapter 2.

<sup>25</sup> *Ibid*.

consent<sup>26</sup> and that it failed to afford any protection of choice.<sup>27</sup> In 1984, Katz revisited these themes in his influential text, *The Silent World of Doctor and Patient*<sup>28</sup> in which he reasserted his 'earlier assessment of law's informed consent vision as overly optimistic and fairy-tale like.'<sup>29</sup> In maintaining his critical stance, he suggested that the 'all too single minded emphasis' of the Court on 'risk disclosures made the objective of giving patients greater voice in medical decision-making well-nigh unattainable.'<sup>30</sup> Significantly, he argued that the doctrine failed to deliver a 'meaningful blueprint for implementing patient self-determination' with an overwhelming focus on 'what goes on in the separate actors heads not what goes on between them.'<sup>31</sup> Similar arguments were reiterated in his 1994 article, 'Informed Consent - Must it Remain a Fairytale?'<sup>32</sup> where he described informed consent as a 'charade' which undermines doctor/patient communication.<sup>33</sup> In the foreword of the 2002 reprint of Katz's *Silent World*, Alexander Morgan Capron emphasised the ongoing relevance of the discussion and described the doctrine as 'at best a waste of time, at worst, an irritant to harmonious relations between physicians and patients and a stimulus for unjustified litigation.'<sup>34</sup> He further emphasised the currency of Katz's work, noting that at that time it had been 'cited and discussed in more than three hundred law review articles and numerous judicial decisions.'<sup>35</sup>

From Katz therefore we see a discussion spanning three decades highlighting the ongoing problems inherent in the doctrine of informed consent. He

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<sup>26</sup> Ibid, 147, whilst this comment was made in 1977, it was echoed 30 years later: „... the emphasis of this doctrine is less on consent than on the duty to inform.“ D Beyleveld and R Brownsword, *Consent and the Law* (Hart Publishing, Portland Oregon, 2007), 349.

<sup>27</sup> Ibid, 159.

<sup>28</sup> Katz, J, *The Silent World of Doctor and Patient* (New York, The Free Press, 1984), reprinted in 2002: (Baltimore, Johns Hopkins University Press, 2002). All page references refer to the later edition.

<sup>29</sup> Ibid, 83.

<sup>30</sup> Ibid, 82.

<sup>31</sup> Ibid, 84. This remains a live issue with Miola raising similar concerns over 30 years later when he suggests that the „focus on risk disclosure rather than the interaction [in both English and Australian law] means that it misses the target in terms of the maximisation of autonomy.“ J Miola, „On the Materiality of Risk: Paper tigers and panaceas' (2009) 17 *Medical Law Review* 76, 108.

<sup>32</sup> (1994) 10 *Journal of Contemporary Health Law and Policy* 69.

<sup>33</sup> Ibid, 81.

<sup>34</sup> Katz, above n.28, x.

<sup>35</sup> Ibid, xv.

describes a lack of doctrinal and judicial clarity resulting in an approach which serves to detract from rather than enrich the doctor/patient relationship. McLean came to the debate after Katz but raised similar concerns. In her 1989 discussion, *A Patient's Right to Know*,<sup>36</sup> McLean addresses the nature of the decision-making process and describes it as a 'deeply human question' as opposed to a 'technical process' and refers to the notion of 'patient choice.'<sup>37</sup> In exploring the expectation of disclosure, McLean asks whether a doctor 'ought to be held to a duty to ensure understanding'<sup>38</sup> and concludes that understanding and rationality can only be determined from the perspective of the patient, explaining that 'what is medically rational may be personally irrational.'<sup>39</sup>

Two themes emerge from McLean's work. The first is the correlation of the nature of the duty with the right from which it derives,<sup>40</sup> and the second is the significance of autonomy and autonomous choice in the development of the doctrine.<sup>41</sup> However, in essence, her concern is the extent to which the doctrine of 'informed consent' as developed, is able to provide the desired protection. McLean challenges the appropriateness of the negligence action due to the 'focus on medical duties' and mere 'tangential dependence on patients' rights.'<sup>42</sup> In McLean's view 'negligence is not concerned with injury to dignity'<sup>43</sup> and as a result the Courts have 'continued to balk at the provision of redress and the imputation of negligence where no measureable harm has actually arisen.'<sup>44</sup> In short, she questions the dedication of the law to the protection of the individual and their autonomy, and asserts that

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<sup>36</sup> Sheila, A.M. McLean, *A patient's right to know: Information disclosure, the doctor and the law* (Dartmouth Publishing Company, Aldershot, 1989).

<sup>37</sup> Ibid, 75.

<sup>38</sup> Ibid, 75.

<sup>39</sup> Ibid, 80.

<sup>40</sup> Ibid.

<sup>41</sup> See for example her comment that the „purpose is to permit the patient the continued exercise of self-determination or autonomy“, (80), „the patient needs ... [to] be able to make an autonomous choice,“ (81), and „reference to patient autonomy as the fundamental value in non-disclosure cases has been echoed in a number of ... decisions“ (90).

<sup>42</sup> Ibid, 87.

<sup>43</sup> Ibid, 91.

<sup>44</sup> Ibid, 92.

despite some 'impressive rhetoric'<sup>45</sup> the individual patient's interests are not served by the existing law.

McLean revisits these concerns in her recent book, *Autonomy, Consent and the Law*<sup>46</sup> in which she refers to the 'spotlight of autonomy' and describes it as the 'transcending principle of modern bioethics.'<sup>47</sup> Of significance here is her recognition of the absence of any 'precise meaning of autonomy'<sup>48</sup> and her challenge to the capacity of the consent doctrine to protect the interests of the autonomous individual.<sup>49</sup> Once again she asserts that the 'fundamental rules of negligence action seem ill-suited to the focus on individual choice that respect for autonomy would presumably demand'<sup>50</sup> and suggests that 'consent law bears only a very limited relationship to any particular concept of autonomy.'<sup>51</sup>

Whilst I have chosen to highlight the work of these two authors, it is important to acknowledge the sheer breadth of work on the question of 'informed consent.' There have been numerous books written on the topic,<sup>52</sup> and there is an ongoing struggle to identify the common threads of the doctrine and clarify its goals and aims. There is, however, one point of agreement that serves as an appropriate starting point to our discussion here: the common position of the majority of scholarly (and judicial) discussions is that the doctrine of informed consent aims to protect the decision-making authority of the individual, usually described as either autonomy or self-

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<sup>45</sup> Ibid, 98.

<sup>46</sup> Sheila, A.M, McLean, *Autonomy, Consent and the Law* (Routledge-Cavendish, London, 2010).

<sup>47</sup> Ibid, 6.

<sup>48</sup> Ibid, 37.

<sup>49</sup> Ibid, see for example her discussion at 93 where she suggests that „the development of a generalised standard ... is inherently inimical to the individual patient and, *ex hypothesi*, to respect for actual autonomy.“

<sup>50</sup> Ibid, 93.

<sup>51</sup> Ibid, 215.

<sup>52</sup> See for example, Neil C. Manson and Onora O'Neill, *Rethinking Informed Consent in Bioethics* (Cambridge University Press, Cambridge, 2007), R.R. Faden and T.L. Beauchamp (with Nancy King), *A History and Theory of Informed Consent* (Oxford university Press, New York, 1986), J.W. Berg, P.S. Appelbaum, C.W. Lidz and L.S. Parker, *Informed Consent: Legal Theory and Clinical Practice* (2<sup>nd</sup> ed, Oxford university Press, New York, 2001) and A.R. Rosoff, *Informed Consent* (Rockville, Aspen, 1981), D.Beyleveld and R.Brownsword, *Consent and the Law* (Hart Publishing, Portland Oregon, 2007) to name but a few.



determination.<sup>53</sup> An equally common position is the doubt that this goal either is or can be achieved. There is yet to be a satisfactory conclusion to this debate and it is this inconclusiveness that provides the impetus for my thesis.

Despite the thorough coverage of 'informed consent' it remains a live issue and the question as to whether or not the interests of the patient are truly protected remains open.<sup>54</sup> The broader question of what is the nature of the interest that the law is seeking to protect (or ought to protect) is also open.

It is worth pausing here to recognise that the concerns raised in this discussion have been considered elsewhere. Indeed, in the sunset phase of writing this thesis, McLean's *Autonomy, Consent and the Law*<sup>55</sup> was published and begins with similar criticisms of the nature of the doctrine of informed consent and the manner in which the law protects (or rather, does not protect) the autonomous individual. The point of departure from this, and other, work is that my discussion will focus on the quality of the information and the nature of the loss sustained. The focus of McLean's work is on the nature of the doctor/patient relationship and a consideration of autonomy in specific situations.<sup>56</sup> This thesis will of course consider the work of McLean and other scholars and build on their arguments as it moves away from informed consent towards informed choice.

This thesis will do more than merely add to the debate. It will mark a significant departure from the discussions regarding the right to self-determination, the nature of the test for standard of care and the question as to whether there ought to be a doctrine of informed consent. My thesis will

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<sup>53</sup> Although both of these terms were specifically rejected by the High Court of Australia in *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ). See Back to basics: Is informed consent a part of our law? (at [1.130]) and more specifically Chapter 4 for an elaboration of the High Court's position regarding autonomy.

<sup>54</sup> See for example the recent paper by Jose Miola, 'On the Materiality of Risk: Paper tigers and panaceas' (2009) 17 *Medical Law Review* 76 or Neil C. Manson and Onora O'Neill, *Rethinking Informed Consent in Bioethics* (Cambridge University Press, Cambridge, 2007), and of course Sheila A.M. McLean, *Autonomy, Consent and the Law* (Routledge-Cavendish, London, 2010).

<sup>55</sup> (Routledge-Cavendish, London, 2010)

<sup>56</sup> McLean has a Chapter on the role of autonomy in the following situations: the end of life, pregnancy, genetic information and organ transplantation.

demonstrate that the protection of the individual right to pre-treatment advice is essential but that it cannot be achieved by focussing on tests for professional standard of care, the appropriateness of the negligence framework or questions of the role of self-determination. An even clearer departure from the existing literature and judicial discussion is my rejection of consent as relevant to the provision of pre-treatment advice. I will argue that the debate should be refocussed with a clear identification of the true nature of the harm sustained. In denying the patient access to appropriate information, the doctor is denying them the right to consider all realistic options and therefore make a choice based upon appropriate levels of information. The action should therefore be framed as informed choice not informed consent.

### *The question of damages*

[1.40] The thesis will not, however, attempt to analyse the appropriate remedy or measure of damages for this loss. I assert at the outset that the law has consistently (and comfortably) redressed intangible losses such as loss of expectation of life, loss of amenities of life and pain and suffering. Whilst mental harm (previously nervous shock) had a chequered history because of the intangibility of the loss it is now an established and accepted part of our law. Significantly, in *Tame and Annetts*<sup>57</sup> that the High Court asserted that psychiatric harm 'is not damage of a different kind from physical injury.'<sup>58</sup> Thus the intangible nature of a dignitary harm does not represent an insurmountable obstacle to the model espoused in this thesis. The nature of remedies is, however, outside of the scope of a thesis focusing on the essence of the loss sustained. That is a discussion best left for another time and is therefore put to one side for now.

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<sup>57</sup> *Tame v State of New South Wales; Annetts v Australian Stations Pty Ltd* (2002) 211 CLR 317. Mental harm is, of course, now given legislative recognition under the Civil Liability Acts: *Civil Law (Wrongs) Act 2002* (ACT) Part 3.2, *Civil Liability Act 2002* (NSW), Part 3, *Civil Liability Act 1936* (SA) s53, *Civil Liability Act 2002* (Tas) Part 8, *Wrongs Act 1958* (Vic), ss72-73, *Civil Liability Act 2003* (WA) Part 1B.

<sup>58</sup> *Ibid*, 368, McHugh J.

## Methodology

[1.50] My argument begins from the position that informed consent has emerged from a series of judicial decisions that have, paradoxically, denied its validity as a term. Borrowing from Frankfurter J in *Tiller*<sup>59</sup> we have an example of a 'legal test' which perhaps began its existence as 'an expression', has been repeatedly raised in case law and is now viewed as a legal doctrine.<sup>60</sup> But is it coherent and does it have meaning? That is the central problem for my thesis which will be addressed through careful analysis of the law across three jurisdictions<sup>61</sup> followed by a close consideration of the two central themes that I will highlight throughout the analysis: defining autonomy and the essential role of choice and choice theory. This discussion will move towards a resolution centred on the identification of a new model of loss and a doctrine labelled 'informed choice' as opposed to 'informed consent.'

This conceptual analysis will necessarily cross disciplines from the law to philosophy and bioethics. This cross-over will only occur when needed to lend clarity to the discussion and is essential to critical analysis of judicial usage of such concepts as 'autonomy.' But first and foremost, this is an analysis of a legal doctrine and therefore does not pretend to be an authoritative analysis of either autonomy or choice.

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<sup>59</sup> *Tiller v Atlantic Coast Line Railroad Co* 318 US 54 (1943) (Frankfurter J). Refer to the quote, above n. 1

<sup>60</sup> *Ibid*, 68.

<sup>61</sup> Australia, the United Kingdom and the United States of America. I have chosen to omit the equally relevant jurisdiction of Canada as it would not add anything substantive to the debate. New Zealand is also put to one side as it operates under a different system, relying on the New Zealand Code of Health and Disability Services Consumers' Rights, 1996. The differences (and similarities) to be found in the three chosen jurisdictions serve to highlight my concerns, demonstrate the practical reality that whilst different language is used there is little substantive difference and most importantly, have developed in reference to each other.

### *A joining of two concepts*

[1.60] The term 'informed consent' sees, in the words of Beyleveld and Brownsword, the attempted marriage of 'not just two elements but two doctrines: one a doctrine of informational obligation which, contingently bears on consensual decision-making; the other a defence of consent to an intentional tort.'<sup>62</sup> We therefore need to ask not only are they compatible but does this 'marriage' work?

Part I of this thesis focuses on the first stage of the enquiry and explores the way that the law addresses the adequacy of any pre-treatment advice which is a process of identifying the appropriate standard of care. The focus of the discussion here is on the patient's needs and the doctor's response to those needs. Part II of the thesis considers the other partner in this 'marriage', the issue of consent to treatment. This necessarily involves a consideration of the causative stage of the negligence enquiry.

The judicial enquiry begins with the provision of information, and involves an analysis of the information that enables a patient to make a decision about the options available to them. This information, in accordance with the requirements of *Rogers v Whitaker*,<sup>63</sup> is not limited to what the doctor believes the patient ought to know. The information must include all factors that the doctor either knows, or ought to know, is material to the patient. The explanation of materiality contained in *Rogers v Whitaker* is something that 'a reasonable person in the patient's position ... would be likely to attach significance to.'<sup>64</sup> This then is the first part of 'informed consent' and forms the substance of the enquiry into the appropriate standard of care focusing on the concept of materiality. The question is: 'What ought the doctor to have

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<sup>62</sup> D Beyleveld and R Brownsword, *Consent and the Law* (Hart Publishing, Portland Oregon, 2007), 174.

<sup>63</sup> (1992) 175 CLR 479 is the key „informed consent“ decision in Australia and will be considered in some detail throughout this thesis.

<sup>64</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

told the patient?' And the answer is: 'Everything that is material to that patient in their decision-making process.'

At this stage the reference to an autonomous patient is clear and logical. The test focuses on what this patient, before this doctor, in this situation would deem important. It makes sense then that in *Rosenberg*, Justice Kirby referred us back to the seminal American decision of *Schloendorff* and the principle that 'each individual has a right to determine what shall be done with his own body.'<sup>65</sup> The significance of the *Schloendorff* statement of autonomy is a repeated theme throughout the scholarly discussions of informed consent, with firm statements along the lines of 'the concept of informed consent has its roots in a recognition of the patient's right to self-determination,'<sup>66</sup> and, importantly informed consent 'fixed its roots in *Schloendorff*.'<sup>67</sup> Thus informed consent is popularly, judicially and academically described as resting on the principles propounded in *Schloendorff* which focus on bodily integrity and consent to contact. Significantly, this foundational decision is not at all concerned with the provision of advice prior to treatment or the expected standard of care of the doctor when giving that advice. It was in fact addressing the consent to surgery for a tumour and was therefore a straightforward trespass case.

## *Part I*

[1.70] Part I will track and explain the development of the law and the concerns of the judiciary. The aim of this Part is to clearly identify the foundational principles of the doctrine as expressed in the duty stage of the enquiry. This Part of the discussion will explore the tension between

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<sup>65</sup> *Schloendorff v Society of New York Hospital* 105 NE 92 at 93 (1914). See also *Salgo v Leland Stanford Jr University Board of Trustees* 317 P 2d 170 at 181 (1957); cf Monks, „The Concept of Informed Consent in the United States, Canada, England and Australia: A Comparative Analysis“, (1993) 17 *University of Queensland Law Journal* 222, 223 . As cited by Kirby J in *Rosenberg* [142].

<sup>66</sup> Gerald Robertson, „Informed Consent to Medical Treatment“ in Sheila A.M. McLean (ed), *Medical Law and Ethics* (Aldershot, Ashgate, 2002) 85.

<sup>67</sup> Leonard L. Riskin, „Informed Consent: Looking for the Action“ (1975) *University of Illinois Law Forum* 580, 582.

professional standards and individual needs which are particularly relevant to the question of pre-treatment advice. We will observe the intricate debate regarding the appropriate test for standard of care and ultimately, the somewhat triumphant rejection by the High Court of Australia of the accepted approach in the United Kingdom and subsequent adoption of a patient centred 'materiality' test.

## *Part II*

[1.80] Part II will focus on the second partner in this uneasy marriage: consent. The focus here is on the vexed question of causation. Negligence turns on the identification of a link between the breach of duty (discussed in Part I) and the manifestation of harm. We will have seen in Part I that the focus of the Courts, at the duty stage of the enquiry, is on the right of the patient to an appropriate amount of information. Part II will explore the struggle to link this right to information to a physical harm arising out of medical treatment. It will be argued that the importation of the language of trespass at this stage of the enquiry undermines the protection of patient interests at the heart of the duty enquiry. This presents the Courts with the impossible task of linking the failure to fully inform the patient with an unrelated physical harm.

As well as drawing together the themes of the three jurisdictions under consideration, this Part will also conclude with a brief consideration of the role of policy in judicial decision-making. The repeated judicial calls on policy during the causative enquiry, will have been highlighted throughout the critical analysis here. This raises the question as to whether or not these references to policy involve a consistently defined (or perhaps even definable) concept. This discussion will challenge the consistency of the application of 'policy' in the 'informed consent' decisions and concludes that it usually masks individual appeals to what is 'just' or 'right' in the circumstances.

### *Part III*

[1.90] Part III of the thesis will focus on the two core themes that logically emerge from the discussions in Parts I and II: autonomy and rejection of the notion of consent. The autonomous individual and the right to self-determination is central to the doctrine of 'informed consent' and Part III begins with an exploration of this complex ideal. Members of the judiciary repeatedly and uncritically refer to notions of autonomy but stop short of defining it. In Part III we will see that this is problematic as there is no consistent definition or understanding of autonomy. It is from this discussion that a proposed adoption of a single purposive definition of autonomy will emerge as a model for judicial consideration of the pre-treatment discussion. This model is based on the ideal of narrative autonomy,<sup>68</sup> and is consistent with the interest of obtaining complete advice and being in control of the story of one's own life.

Part III will then identify the process that truly sits at the heart of the 'informed consent' debate: choice. Here we will see that the ongoing struggle for judicial clarity is driven by the incongruity of the dignitary harm of denial of information being linked with a subsequent physical loss. It will be clear from all of the preceding discussions that the provision of information is not about consent; rather it is about the deeply individual and personal process of choice. Part III will therefore see a firm retreat from the doctrine of 'informed consent' towards a new doctrine of 'informed choice.' It is here that the central arguments of the thesis will be drawn together and clear conclusions made.

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<sup>68</sup> At its simplest, the ideal that each individual is the „narrator“ of their own story and able to create their own story from the information provided to them.

## *Sally*

[1.100] It is always important to remember that the scholarly and judicial consideration of informed consent is deeply human in nature. They focus on individuals who are vulnerable and reliant on the expertise of another. The discussion ought then to focus on the vulnerability of the individual and the consequent need to address the harms arising out of the doctor/patient interaction. We begin with an individual who is, by definition, unwell and at risk. They go to see a doctor and seek advice as to appropriate treatment. At this point, the law says that the information given to the patient must be everything that is material to that patient. To demonstrate what then happens to patients (and later plaintiffs), I will introduce Sally, a hypothetical patient who will be called upon throughout this thesis as a practical demonstration of the theory and law under discussion.

Sally's situation will be described in detail in Part I<sup>69</sup> and she will provide insight into the practical application of the different tests analysed in Parts I and II. She will also support the presentation of Choice in Part III.

### **The current law**

[1.110] My deconstruction of the doctrine of informed consent and reconstruction of a doctrine of informed choice requires a detailed analysis of the existing law and an exploration of the themes and issues that emerge from this analysis. In addressing the current law there are two preliminary issues that warrant a brief exploration. First I will explain the trespass/negligence divide. The core of my rejection of consent is that it is an enquiry best suited to trespass and thus outside of the scope of a negligence enquiry. If this argument is to be understood a clarification of the divide between the two causes of action is necessary. The second issue relates to my challenge of the

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<sup>69</sup> See Chapter 5, „The more things change, the more they stay the same“ (at [5.10]) and „Sally“ (at [5.20]).



current law. I have suggested (and will continue to argue) that the High Court has rejected 'informed consent' and I must therefore address the question of whether or not 'informed consent' is even a part of our current law.

### *The trespass/negligence divide*

[1.120] At law there is a clear distinction between trespass and negligence. This is a significant distinction because the foundations of the doctrine of informed consent were laid in actions in trespass but the main body or structure of the doctrine is founded in actions in negligence. Before critiquing that structure we need to identify why there was a move away from trespass and ask whether or not it was an appropriate one.

Consent to treatment is essential and its primary role is that it 'renders lawful what would otherwise constitute a battery'.<sup>70</sup> Despite the label of informed consent, judicial considerations of the provision of pre-treatment advice have revealed a reluctance to link poor advice to the intentional tort of trespass to the person, presumably because of the 'overlap with the criminal offence of assault.'<sup>71</sup> 'Informed Consent' is therefore a creature of negligence law, a position clearly stated by the High Court in *Rogers v Whitaker*:

Anglo-Australian law has rightly taken the view than an allegation that the risks inherent in a medical procedure have not been disclosed to the plaintiff can only found an action in negligence and not in trespass; the consent necessary to negative the offence of battery is satisfied by the patient being advised in broad terms of the nature of the procedure to be performed.<sup>72</sup>

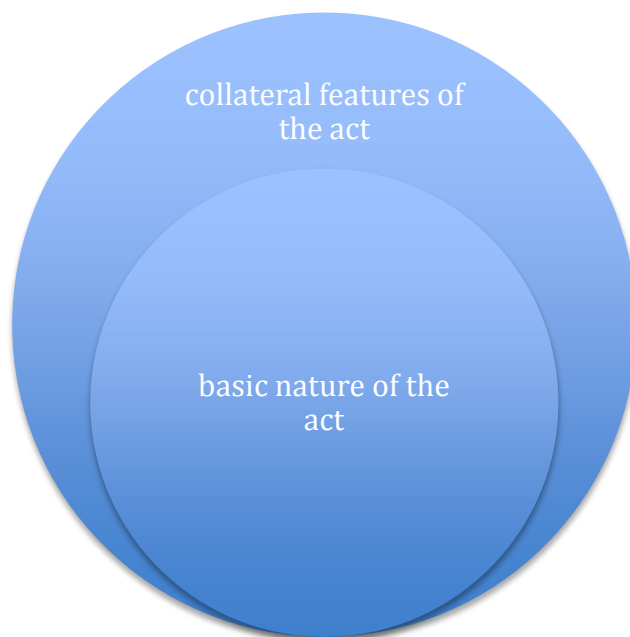
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<sup>70</sup> M. Jones, *Medical Negligence* (3<sup>rd</sup> ed, Sweet and Maxwell, London, 2003), 453.

<sup>71</sup> *Ibid*, 448.

<sup>72</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 491 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ). At this point the Court also referred to the UK decision of *Chatterton v Gerson* [1981] QB 432 and the Canadian decision of *Reibl v Hughes* [1980] 2 SCR 880, 888-892.

It follows that if a patient is aware of the nature of the treatment and the extent of the bodily invasion, but is unaware of some of the risks inherent in the treatment, they will be deemed to have consented to the treatment despite the gaps in the advice provided. This distinction has been described by Beyleveld and Brownsword as 'thicker and thinner conditions for valid consent',<sup>73</sup> and diagrammatically represented by Somerville:



*'The outer [circle] represents all the consequences or risks to which the patient must consent if liability in tort (battery or negligence) for failure to obtain consent is to be avoided. The inner [circle] represents the factors that make up the basic nature and character of the act of touching. Failure to obtain consent to these factors will give rise to a cause of action in battery. Thus, whether or not battery lies depends on where the inner line is drawn.'*

FIGURE 1: TRESPASS/NEGLIGENCE DIVIDE.<sup>74</sup>

In her article, Somerville goes on to question the appropriateness of the exclusion of risks from the nature of the act, raising the issue that perhaps 'some risks are so serious that they necessarily relate to the basic nature and

<sup>73</sup> D. Beyleveld and R. Brownsword, *Consent and the Law* (Hart Publishing, Portland Oregon, 2007), 183.

<sup>74</sup> M. Somerville, 'Structuring the Issues in Informed Consent' [1981] 26 *McGill Law Journal* 740, 743. This diagram is a slightly modified version of that presented by Somerville (in shape only) and the explanation is in her words.

character of an operation.<sup>75</sup> Similarly, Beyleveld and Brownsword describe this approach as setting a 'relatively weak informational standard for a valid consent,'<sup>76</sup> suggesting that it is conceivable that information regarding the risks of the treatment could be included in discussions regarding the nature of the treatment. This is an interesting alternative view, which will not be pursued here. My discussion will proceed on the grounds that, consistent with the views of the High Court as expressed in *Rogers v Whitaker*, once the patient has been informed of the nature of the treatment, then any action in trespass will fail. The nature of the treatment is narrowly defined to include the nature of the touching<sup>77</sup> and does not extend to considerations of risks.

The line between trespass and negligence is a clear one. Importantly, it is not a line that will be challenged in this discussion, indeed I will be arguing that it ought to be maintained and more clearly adhered to. Consent to treatment (and trespass) are distinct from the provision of advice (and negligence) and therefore notions of consent should not be imported into negligence. This position is fundamental to my thesis and will be explored in some depth. As the law exists at the moment consent and pre-treatment advice remain conceptually linked and it is therefore necessary at the outset to determine why this is so. The answer can be found in a review of the evolution of the legal consideration of consent from straightforward agreement to (or refusal of) medical treatment to the more complex concept of the provision of pre-treatment advice (which involved the addition of the epithet 'informed'). Beyleveld and Brownsword point to 'judicial reservations' about the role of consent in considerations of the provision of pre-treatment advice and suggest that 'whilst the language of consent has been carried forward from the settled understanding of the defence to battery,' the doctrine of informed consent 'might not actually be grounded in the idea of a patient giving

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<sup>75</sup> Ibid, 747.

<sup>76</sup> Beyleveld and Brownsword, above n.73, 173.

<sup>77</sup> That is information regarding the mechanics of the treatment and the body part to be treated.

consent.<sup>78</sup> The High Court in *Rogers v Whitaker* specifically rejected the terminology<sup>79</sup> yet we consistently see reference to consent in the scholarly literature<sup>80</sup> and the protection of personal integrity continues to provide the justification for the of the doctrine of informed consent.

This relationship between trespass and negligence in the doctrine of informed consent will be discussed in more detail as we progress through my argument, but it is important to acknowledge at this point that trespass protects the personal right to determine what is or is not done to one's own body. It is the very essence of autonomy, the right to decide what is or is not done to one's own body. Negligence on the other hand is traditionally focussed on tangible loss or damage (to property, person or, more recently, economic interests). Indeed, it has been said many times that 'damage is the gist of negligence'.<sup>81</sup> Thus we have two areas of law, one (trespass) focussing on personal integrity through the protection of the right to consent to what is or is not done to one's own body and the other concerned with recompensing for loss or harm (negligence). With the importation of the language of consent into negligence law we find the roots of the concerns that have driven the scholarly debate, not least of which is the apparent inability of the doctrine of informed consent, firmly grounded in negligence, to protect the autonomy of the decision-maker, an interest protected by the law of trespass.

### ***Back to basics: Is informed consent a part of our law?***

[1.130] The conventional wisdom is that informed consent was introduced into Australian law via the decision in *Rogers v Whitaker*,<sup>82</sup> Olbourne<sup>83</sup>

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<sup>78</sup> Beyleveld and Brownsword, above n.73, 171.

<sup>79</sup> *Rogers v Whitaker* (1992) 175 CLR 479. This rejection is detailed in the next section of the discussion, „Is Informed Consent a Part of our Law?“ See also *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 649, 663 (and as discussed in Beyleveld and Brownsword, *ibid*).

<sup>80</sup> Refer discussion above, in particular n.11-n.13.

<sup>81</sup> See for example J. Stapleton, „The Gist of Negligence“ (1988) 104 *Law Quarterly Review* 389.

<sup>82</sup> (1992) 175 CLR 479.

<sup>83</sup> Norman Olbourne, „The Influence of *Rogers v Whitaker* on the practice of Cosmetic Plastic Surgery,“ (1998) 5 *Journal of Law and Medicine* 334.

suggests that the doctrine of informed consent was developed from *Rogers v Whitaker* and involves consent by an autonomous patient who makes an informed decision based on understanding.<sup>84</sup> Others have claimed that, over the years, Australian Courts have slowly shaped the requirements for informed consent and describe *Rogers v Whitaker* as the 'landmark case which added to the mountain of words about informed consent, what it means and how it can be achieved.'<sup>85</sup> Indeed, even in the High Court the decision has been recognised as coming to represent the 'commonly termed notion of informed consent.'<sup>86</sup>

These comments appear uncontroversial on the surface and, in many respects, quite reasonable. Surely if the academic literature, the medical profession and the High Court itself refers to a doctrine of informed consent without much further explanation, then it must be a clear and well developed part of Australian law. It is my position that this is not the case. Whilst there has been a loose adoption of the phrase 'informed consent' to describe an apparently coherent legal doctrine resting on the foundational principle of autonomy, it is far from coherent. It is in fact flawed in both interpretation and application.

To demonstrate this claim, it is best to return to the foundational decision of *Rogers v Whitaker* and take the time to consider what the High Court *actually* decided. It is important to recognise that the Court took care to avoid the adoption of the language of consent and specifically noted that nothing is to be gained by reiterating the expressions used in American authorities such as 'the patient's right to self determination' or even the oft-used and 'somewhat amorphous phrase informed consent'.<sup>87</sup> Indeed, in the words of the Court, 'the right of self-determination is an expression which is, perhaps, suitable to

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<sup>84</sup> *Ibid*, 341 and 342.

<sup>85</sup> Ian Kerridge and Kenneth Mitchell, „Missing the Point: *Rogers v Whitaker* (1992) 175 CLR 479 and the Ethical Ideal of Informed and Shared Decision-making“ (1994) 1 *Journal of Law and Medicine* 239, 239.

<sup>86</sup> *Rosenberg v Percival* (2001) 205 CLR 434, 477 (Kirby J).

<sup>87</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

cases where the issue is whether a person has agreed to the general surgical procedure or treatment, but is of little assistance in the balancing process that is involved in the determination of whether there has been a breach of the duty of disclosure.<sup>88</sup> Furthermore, the term informed consent was described as 'apt to mislead'<sup>89</sup> as it suggests a test of the validity of the patient's consent. Importantly, consent was described as relevant to those cases involving trespass and not negligence; the question before the Court (which was dealing with the provision of advice prior to treatment) was not one of consent.<sup>90</sup> This then is the starting point of the so-called doctrine of informed consent which emerged from the High Court decision of *Rogers v Whitaker*. It is a doctrine resting upon a denial of the very term used to describe it.

### **Towards a doctrine of informed choice**

[1.140] It has been said that a 'basic commitment of the legal system is to respect human dignity,'<sup>91</sup> and in denying access to information the doctor is denying the autonomous right to choose which path to take. The adoption of the term choice in this thesis is critical to the central argument and is informed by the language of the High Court. This thesis presents a challenge to the current doctrine of 'informed consent.' Through an exploration of the current law, combined with analysis of scholarly debate, it will be demonstrated that the appropriate solution is a doctrinal shift away from 'informed consent' towards 'informed choice.'

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<sup>88</sup> Ibid.

<sup>89</sup> Ibid.

<sup>90</sup> Ibid.

<sup>91</sup> Joseph Goldstein, „For Harold Lasswell: Some Reflections on Human Dignity, Entrapment, Informed Consent and the Plea Bargain“ (1974-5) 84 *Yale Law Journal* 683, 691.

# PART I: IT'S A QUESTION OF STANDARDS

## Introduction

This thesis offers a critical analysis of informed consent and will challenge the existing judicial approach to a consideration of pre-treatment advice. To do this it is necessary to begin with a careful, in depth, consideration of the law as it currently functions. The discussion in both Part I and Part II will critically assess the concept of informed consent and address the central question of whether or not the underlying ideals match the practical realities.

The doctrine of informed consent is central to this thesis and even the most cursory glance over the scholarly and judicial considerations of informed consent will reveal that the term itself is problematic. However, if a concept is to be critiqued it is essential that it is provided with a consistent and identifiable label. This means that, despite strongly disagreeing with the use of the term 'informed consent,' (my thesis rests on the strength of this disapproval and rejects the use of the phrase and therefore the essence of, the doctrine in its current form) I will reluctantly conform and use the shorthand phrase. Therefore, any reference here to 'informed consent' is in relation to the legal test of the appropriateness (or not) of the provision of pre-treatment advice.

The analysis of the law in Part I will address some central questions:

1. Is 'informed consent' truly about consent?
2. Who takes the central role (is it the prudent patient or the prudent professional)? and (most significantly),
3. Are we dealing with patient autonomy or professional standard of care? (Or is it about the doctor or the patient?)

In combination the answers to these three questions will permit the identification of the appropriate standard of care to be applied when assessing the advice given by a doctor, to a patient, before the treatment commences.

At first glance, each of these questions appears to be both straightforward and clear, suggesting an equally straightforward and clear answer. This is not the case; acceptable (and consistent) answers are difficult to find. The three principal jurisdictions under consideration are, on one level, consistent only in their inconsistency. We see the Courts in each jurisdiction carefully constructing a test for standard of care that, in their view, differs from the other two jurisdictions. In the United States there is the key decision of *Canterbury v Spence (Canterbury)*,<sup>1</sup> which is viewed as authority for the doctrine of informed consent, whilst in the United Kingdom *Bolam v Friern Hospital Management Committee (Bolam)*<sup>2</sup> combined with *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors (Sidaway)*<sup>3</sup> to reject the notion of informed consent. The third position is that of Australia. Here *Rogers v Whitaker*<sup>4</sup> saw a rejection of the *Bolam* position as well as that of *Canterbury* and purported to introduce a third test of materiality of information and an apparent denial of the concept of informed consent.

Each of the different approaches to the expected standard of care in the provision of pre-treatment advice has one distinguishing feature, which is the nature of the language used. There is a mixture of terms including 'informed consent', 'material information', 'significant information', 'meaningful choice' and of course, 'professional standards.' But when one looks behind the language, seeking the essence of the decisions, it becomes apparent that the

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<sup>1</sup> 464 Fed Report, 2d 772 (1972).

<sup>2</sup> [1957] 1 WLR 582.

<sup>3</sup> [1984] QB 493.

<sup>4</sup> (1992) 175 CLR 479.



differences lie in terminology rather than substance. Close scrutiny of these judgments also reveals that this substance, however it is expressed, fails to deliver on its purported core value of respect for patient autonomy.

Whatever the language used, it is clear that the legal doctrine of informed consent has now been accepted across all three jurisdictions as belonging under the banner of negligence. The negligence enquiry is, of course, a staged one and Part I deals only with the second stage: standard of care.<sup>5</sup> The third stage of the enquiry is of course causation and this will be considered in Part II.<sup>6</sup> The discussion in Part I will provide the background for the critique of the role of causation and will focus entirely on the question of standard of care. We will discover that despite careful linguistic distinctions, the practical outcome is the same. This assertion will be supported by inviting my fictional character, Sally,<sup>7</sup> on a world tour to have her case analysed in each jurisdiction. The proposal is that the outcome will be the same wherever she may be.

This analysis is the first step in unravelling the complexities of informed consent. In doing this we will begin to draw out the common threads and move towards a coherent model of informed choice.

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<sup>5</sup> Duty is not addressed as the doctor/patient relationship is an established duty category and therefore unproblematic.

<sup>6</sup> Defences and damages are beyond the scope of this dissertation.

<sup>7</sup> We were introduced to Sally in the Introduction to the thesis (see [1.100]) and she will have her case reconsidered many times throughout this discussion, serving to illustrate the practical import of the different uses of language across the three jurisdictions.

## Chapter 2: The United States of America

### Introduction

[2.10] The United States is mistakenly described as adhering to a patient-centric doctrine of informed consent with the central authority identified as *Canterbury v Spence*.<sup>8</sup> This seminal decision is best described as the ‘pin-up case’ for informed consent. Courts in both Australia and the United Kingdom refer to the decision as a clear statement of the American position of broad recognition of patient-based information sharing.<sup>9</sup> To describe *Canterbury* as representative of the position across all of the United States is, however, misleading.<sup>10</sup> The approach to ‘informed consent’ in America is not monolithic and, as will be explained in this Chapter, more than half the States have statutory regimes which reject the *Canterbury* test.<sup>11</sup> It is noteworthy that despite the subsequent aligning of *Canterbury* with ‘informed consent’, the *Canterbury* Court itself rejected the notion of ‘informed consent’ as useful.<sup>12</sup>

Despite the discrepancy between the perceived and actual intent of the Court in *Canterbury v Spence*, the case continues to be significant, largely because of the important role it has played in the development (and rejection) of an ‘informed consent’ doctrine in both the United Kingdom and Australia. The significance of the *Canterbury* decision therefore lies in its position of perceived authority. Courts and commentators in Australia and the United Kingdom debate the relevance of the term ‘informed consent’ based on the different standards applied in each jurisdiction.<sup>13</sup> In the United States,

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<sup>8</sup> 464 F. 2d 772 (1972). The High Court in Australia specifically aligned the *Canterbury* judgment with informed consent in *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

<sup>9</sup> *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1985] AC 871, 887-888 and *Rogers v Whitaker* (1992) 175 CLR 479, 490.

<sup>10</sup> This is a common interpretation of this decision, see the discussion below and footnote 44.

<sup>11</sup> See discussion below and refer to footnote 45.

<sup>12</sup> Robinson J at 780 cautioned that the uncritical use of the label informed consent can be misleading. This aspect of the judgment is explored further below.

<sup>13</sup> In the United Kingdom the standard test is described as professional with *Bolam v Friern Hospital Management Committee* [1957] 1 WLR and *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley*

however, there is a broad acceptance of the existence of a doctrine of informed consent which turns on the nature of a physicians' duty to warn the patient of risks inherent in the proposed course of treatment. The view across the jurisdictions in the United States is not consistent with the point of difference being the test for the general measure of this duty.<sup>14</sup> The discussion in this Chapter will demonstrate that despite the perceptions of the United States as having embraced a clear doctrine of informed consent, it is as unclear there as everywhere else.

### **The foundations of informed consent**

[2.20] The evolution of informed consent which is identified with *Canterbury* can be traced to the 'germinal case' of *Schloendorff*<sup>15</sup> in which the primary requirement for patient consent was clearly enunciated by Cardozo J:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages.<sup>16</sup>

The decision in this instance focussed on the tort of trespass to the person (battery) and made no reference at all to the quality of pre-treatment advice. Over time, however, its application has broadened and it is now viewed as being 'emblematic of the law's purported aspiration to protect autonomy',<sup>17</sup> and as we will see, it is almost universally referred to in the informed consent decisions. A point worth noting here is that 'informed consent', which has

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*Hospital & Ors* [1985] AC 871 and in Australia the standard is commonly referred to as patient-centred as developed in *Rogers v Whitaker* (1992) 175 CLR 479.

<sup>14</sup> L.B. Frantz, „Modern Status of views as to General Measure of Physician's duty to inform patient of risks of proposed treatment.“ 88 ALR 3d. 1008, (updated Nov. 2005 Annotation), §2a.

<sup>15</sup> *Retkwa v Orentreich* 154 Misc. 2d 164 (1992, SC of NY County, NY), referring to *Schloendorff v The Society of the New York Hospital* 211 N.Y 125 (1914).

<sup>16</sup> *Schloendorff v The Society of the New York Hospital* 211 N.Y 125 (1914), 129-130 .

<sup>17</sup> Sheila A.M. McLean, *Autonomy, Consent and the Law* (Routledge-Cavendish, London, 2010), 77.

been judicially distinguished from the tort of trespass,<sup>18</sup> is founded on a trespass decision and thus presents a clear potential for conflicting principles. The first significant post *Schloendorff* development was the coining of the term ‘informed consent’ by the *Salgo*<sup>19</sup> Court, closely followed by the shift to the tort of negligence, as opposed to battery, in *Natanson v Kline*.<sup>20</sup> Of significance in these developments was the continued emphasis on the foundational premise of autonomy.<sup>21</sup> Once this foundation was laid, it was a relatively small step to the maturation of the doctrine of patient-centred informed consent developed by the *Canterbury* Court.<sup>22</sup> And it was during this evolutionary phase that the focus of the Courts shifted to the quality of pre-treatment information provided by the doctor. We begin to see the pre-occupation with the appropriate test for standard of care.<sup>23</sup> It is my position that this ongoing struggle to identify the appropriate test for standard of care masks the true nature of the problem with the current doctrine of ‘informed consent’. As we will see in further discussions, despite the care taken by the Courts to identify the most appropriate test, it is of little practical import. The outcome of both tests is the same and breach of duty is readily identified, and it is questionable that the autonomy of the patient is ultimately protected.

As indicated at the outset, this part of the thesis will involve a close consideration of a number of key decisions, a process that most logically begins with *Canterbury*. The facts of the case are straightforward: the appellant suffered from back pain and agreed to an operation but was not informed of the risk of paralysis inherent in the procedure. The day following the operation, he fell out of bed and suffered some paralysis. He then

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<sup>18</sup> Refer to Figure 1 (in the Introduction) and the accompanying discussion regarding the trespass/negligence divide in this context (at [1.120]).

<sup>19</sup> *Salgo v Leland Stanford Jr University Board of Trustees* 317 P.2d 170 (1957).

<sup>20</sup> *Natanson v Kline* 186 Kan 393 (1960). For an excellent discussion of the history of the evolution of the doctrine refer R.R. Faden, T.L. Beauchamp, (with Nancy King), *A History and Theory of Informed Consent*, (Oxford University Press, New York, 1986), Chapter 4.

<sup>21</sup> *Ibid*, 132.

<sup>22</sup> *Canterbury v Spence* 464 F.2d 772, (1972), was an appeal to the Court of Appeals District of Columbia Circuit, the judgment was delivered by Robinson J and the decision of the District Court was reversed, it was remanded to the District Court for a new trial.

<sup>23</sup> This preoccupation is consistent across all three jurisdictions and the struggle to find the appropriate test will be explored as we analyse the seminal cases in more detail below.

underwent a second procedure and whilst this resulted in an improvement in his condition, he continued to rely on crutches and suffer ongoing paralysis and resulting incontinence.

Of significance to the decision was the fact that neither the patient nor his mother (who signed the consent form after the original surgery) questioned the physician regarding the risks inherent in, or any possible alternatives to, the procedure. There appeared to be unquestioning acceptance that this was the most appropriate treatment.

In delivering his judgment, Robinson J specifically noted the need to look beyond proficiency in diagnosis and treatment when determining the scope of a physician's duty of care with the duty being founded on more than simply the provision of treatment. Some insight into the preferred approach of the Court was provided by Robinson J's suggestion that the physician's training enables a 'self-satisfying' evaluation of the question of whether or not a particular procedure should be undertaken.<sup>24</sup> Such an evaluation was viewed by the Court as more properly belonging to the patient. It was the clear prerogative of the patient and not the physician to determine the direction in which their interests seemed to lie.<sup>25</sup> Thus we see the emergence of a patient-centred enquiry which now forms the basis of judicial and scholarly considerations of informed consent.

Once the patient was identified by the Court as the one in control of the decision-making process, it became necessary to establish how the patient was to ascertain what was in their best interests. The Court returned to first principles by appealing to the basic assumptions of *Schloendorff*, emphasising that true consent requires the 'informed exercise of a choice and that entails an opportunity to evaluate knowledgeably the options available.'<sup>26</sup> Of note

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<sup>24</sup> *Canterbury v Spence* 464 F.2d 772, (1972), 781 (Robinson J).

<sup>25</sup> *Ibid*, 784.

<sup>26</sup> *Ibid*, 779.

here is the early emergence of the language of choice which hints at a recognition of the process behind the giving of consent. Unfortunately it is an idea that fails to reach maturation in this and later judicial discussions and whilst we see many and varied references to choice, it is never given the prominence that I argue is necessary to give substance to the legal consideration of pre-treatment advice. In *Canterbury* we do however see a Court focussing on the patient and it is this focus that is generally referred to when the authority of *Canterbury* is either adopted or rejected.

Whilst it is true that the individual interests of the patient appear to drive the *Canterbury* decision, it must be recognised that the discussion does not end there; it is but the starting point. Before the Court considered the content of the physician's duty of care, it carefully retreated from the patient focus and called for the adoption of a broader view. For a complete understanding of the basic principles espoused by the *Canterbury* Court, it is essential that this preliminary stage in the discussion be carefully considered and yet it is routinely overlooked and understated.

The significant role of *Canterbury* as a key decision in the development of informed consent is now cemented and it has been described as having 'played an iconic and influential role in commentary on the issue of consent.'<sup>27</sup> The decision has risen to a position of prominence despite the clear caution against uncritical adoption of the language of 'informed consent' and the description of the term as potentially misleading.<sup>28</sup> It is important to recognise that in the view of the *Canterbury* Court, it was inappropriate to focus on the patient's understanding of the advice or their decision to consent. The essence of the enquiry lay in a consideration of the nature and content of the physician's divulgence.<sup>29</sup> The interrelationship between adequate disclosure and informed consent was acknowledged by the Court; it was

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<sup>27</sup> McLean, above n.17, 77.

<sup>28</sup> *Canterbury v Spence* 464 F.2d 772, (1972) 780, (Robinson J).

<sup>29</sup> *Ibid.*

described as ‘two sides of the same coin,’<sup>30</sup> but to attempt to ground the discussion in the language of informed consent, as opposed to duty, was said to be misdirecting the enquiry. The Court emphasised that the language of informed consent implies that the patient’s comprehension is decisive when, in reality, the question to ask is whether or not the physician has made a ‘reasonable effort to convey sufficient information.’<sup>31</sup> Thus we have a judgment which begins by looking directly at the patient and the right of autonomy but swiftly switches focus to the doctor and his/her knowledge and skill. This altered focus reduces the significance of the patient and emphasises the role of the doctor as a professional. In light of this significant focal shift, the question I will explore more fully throughout this and subsequent Chapters, is whether or not it is appropriate to rely completely on an examination of the content of the duty of a doctor as a professional in order to determine what information is material to the decision-making of the individual patient.

The emphasis on the doctor as a professional comes from the Court’s recognition of the significance of the expertise of the physician which places them in the position of power in the relationship. The patient on the other hand, comes to the therapeutic relationship with little to no knowledge leaving the physician to bear the responsibility of providing appropriate ‘enlightenment with which to reach an intelligent decision.’<sup>32</sup> Inherent in this choice of language is the implication that the physician, not the patient, is the one who is best equipped to identify what constitutes an intelligent decision and it is their role to provide sufficient information to guide the patient in the appropriate direction. Alongside this acknowledgment of power sits the Courts’ clear recognition of the duty to disclose. The legal significance of the duty arises from the need to protect the patient from the risk of physicians reaching ‘self-satisfying’ conclusions as to appropriate advice and treatment

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<sup>30</sup> Ibid, 780 refer fn.15.

<sup>31</sup> Ibid, fn.15.

<sup>32</sup> *Canterbury v Spence* 464 F.2d 772, (1972) fn15, (Robinson J).

which could undermine the relationship of trust.<sup>33</sup> These conflicting positions left the Court struggling to reconcile the needs and expectations of the patient with the established role of the physician.

*Canterbury* began with the legitimate expectation of a patient that adequate information will be provided. The test as to whether or not this expectation had been met then focused not on the patient's understanding, but on the content of the physician's disclosure. The core of the test applied in *Canterbury* lies in a determination of adequate disclosure. It is at this point in the enquiry that the Court, despite earlier resiling from the language of consent, began to adopt the terminology that has led to the common interpretation of this as a case about informed consent.

With the content of the duty identified as the foundational question, the Court sought to establish a clear test of the standard of disclosure with the central question being, who is to determine what constitutes adequate information? Despite asserting that the physician is in the best position to determine appropriate information so as to facilitate 'enlightenment' and an 'intelligent decision', the *Canterbury* Court rejected the position previously adopted by some States, of turning to the medical fraternity for advice on what risks are deemed to be material and routinely presented to patients contemplating particular procedures.<sup>34</sup> The position adopted by the Court was that to rely on professional practices is to remove the decision making power from the Court and place it in the hands of the medical profession and so it was determined that the patient's cause of action is not dependent upon the existence and non performance of a relevant professional tradition.<sup>35</sup> It is this proposition that has led directly to the interpretation of the decision as being a patient, as opposed to physician-centred one.

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<sup>33</sup> Ibid, 782.

<sup>34</sup> As we will see in Chapter 3, this is also the approach of the Courts in the United Kingdom and is most commonly associated with *Bolam v Friern Hospital Management Committee* [1957] 1 WLR and *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1985] AC 871.

<sup>35</sup> *Canterbury v Spence* 464 F.2d 772, (1972) 784, (Robinson J). We will see in Chapter 4 that this position was later mirrored in Australia in *Rogers v Whitaker* (1992) 175 CLR 479.



With professional practices relegated to the back seat, the next stage of the enquiry was to determine the actual scope of disclosure. The Court recognised that this is a question of standard of care with the standard of a professional being above that of the ordinary citizen. Significantly, the Court clearly and specifically rejected the full disclosure standard, describing any expectation that the physician discuss every risk of proposed treatment, no matter how small or remote, as prohibitive and unrealistic.<sup>36</sup>

At this point, the Court was clearly endeavouring to arrive at a test that was both realistically attainable and appropriately respectful of the right of the patient to possess sufficient information to make an 'intelligent choice.' The question then became one of how to determine where, along the continuum of available information, reasonable and appropriate information lay and, perhaps more importantly, by whom and how was it to be determined?

Despite the clearly stated view that the standard was to be determined by the law, the evidentiary relevance of professional practice was readily accepted. The Court was not prepared, however, to limit its enquiry to an examination of what the profession thought was (or was not), appropriate. The scope of the information required was to be shaped by the patient's right of self-decision and need for information material to the decision. The test of materiality required a consideration of what the patient would consider 'significant' to their decision.<sup>37</sup> The language adopted at this point in the enquiry touches upon self-determination and issues of autonomy, which are traditionally identified as central to the discussion of 'informed consent.' However, in the absence of a clear doctrine of 'informed consent,' the Court here was struggling to protect the patient while creating an attainable standard for the physician. The potential for a clash of interests is well

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<sup>36</sup> Ibid, 786.

<sup>37</sup> Ibid, 785-6. The terminology here is important, as similar language was later employed by the High Court in *Rogers v Whitaker* (1992) 175 CLR 479.

illustrated by the curious position adopted by the Court when it stated that the materiality of a piece of information (that is, the materiality of the information to the patient in their decision making process) is always judged, at first instance, by the physician:

Of necessity, the content of the disclosure rests in the first instance with the physician. Ordinarily it is only he who is in position to identify particular dangers; always he must make a judgment, in terms of materiality, as to whether and to what extent revelation to the patient is called for.<sup>38</sup>

When considered closely, it becomes apparent that the *Canterbury* judgment has some internal contradictions which have often been overlooked in subsequent interpretation and application. It has come to stand as authority for the doctrine of 'informed consent,' despite the Court's rejection of the term as useful. It develops a test which purports to be measured by a patient-centred standard of materiality but one which is to be determined, at least in the first instance, by what the physician believes to be material. The result is a judgment lacking both clarity and certainty. It has also come to stand for a doctrine that was, on some levels, rejected by the Court. Perhaps the problem lies in the fact that when one is considering the notion of consent, there is no 'bright line separating the significant from the insignificant.'<sup>39</sup> Despite this weakness in the judgment, it has come to mean so much more than a mere setting of a standard of disclosure. It has now assumed an apparently authoritative position and is interpreted as being the key 'informed consent' case. The question is why and how has such a broad and perhaps erroneous interpretation been given to a relatively narrow decision?

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<sup>38</sup> Ibid, 786.

<sup>39</sup> Ibid, 787.

## Interpretations of Canterbury

### *The Courts*

[2.30] The aim of the *Canterbury* Court was to clearly enunciate a test for determining whether sufficient information was given to a patient prior to a particular course of treatment. Such a test did not turn on patient comprehension or informed consent, yet the accepted interpretation of the decision embodies both of these principles.<sup>40</sup> *Canterbury* is now the exemplar for the autonomous patient test as reflected in a patient-centred doctrine of informed consent. This perception of the case has gradually evolved through subsequent interpretations and apparent applications of the decision. In endeavouring to trace the emergence of a doctrine of informed consent, it is informative to explore subsequent judicial treatments and to ascertain why (or indeed how) it has come to mean so much more and to be given such a broad interpretation.

The core of the problem really lies in the evident difficulty of giving content to the duty of disclosure. It is readily recognised by the Courts that the scope of the disclosure required of physicians defies simple definition.<sup>41</sup> In an attempt to create certainty, the Courts have sought to develop a clear test based on recognisable principles and readily accepted terminology. This has meant that the cautionary note in *Canterbury* has been ignored and the language of informed consent has been embraced by the American judiciary in an at times

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<sup>40</sup> See for example *Carr v Strode* (1995) 904 p.2d 489 in which Moon CJ in the Supreme Court of Hawai'i described *Canterbury* as „spearheading patient oriented standard of disclosure for actions founded in the doctrine of informed consent“ (494) and *Ketchup v Howard* (2000) 247 Ga.App, 54 where the Court of Appeals of Georgia viewed *Canterbury* as embodying the common law doctrine of informed consent and in the literature, R.R. Faden, T.L. Beauchamp, (with Nancy King), *A History and Theory of Informed Consent* (Oxford University Press, New York, 1986), 136 and 139 clearly aligns *Canterbury* with informed consent and M.A. Berger, A. D. Twerski „Uncertainty and Informed Choice: Unmasking Daubert“ (2005) 104 *Mich. L. Rev.* 257, 271 describes *Canterbury* as pushing informed consent into the limelight. Outside of the United States Courts in both the United Kingdom and Australia link informed consent with *Canterbury*, refer *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1985] AC 871, 898 Lord Bridge, (Lord Keith concurring) describe informed consent as being based on *Canterbury* and in the process of rejecting informed consent the High Court in *Rogers v Whitaker* (1992) 175 CLR 479, 490 ((Mason CJ, Brennan, Dawson, Toohey and McHugh JJ), specifically refer to *Canterbury*.

<sup>41</sup> *Cobbs v Grant* 8 Cal.3d 229 (1972), 244.

misguided attempt to acknowledge the rights of the autonomous patient. Of interest is the fact that despite the clear split in doctrinal approach,<sup>42</sup> the rationale and language employed to support the different tests remains the same. In all jurisdictions within the United States, there is an unquestioning acceptance of the idea of informed consent and the significance of the autonomous patient. What has emerged as a result is a test which, in the hands of different Courts (and different legislatures), purports to have different content but is in effect a hybrid test embracing elements of both the professional and the patient centred standards.<sup>43</sup>

Despite the repeated reference to *Canterbury* as a 'landmark'<sup>44</sup> decision, it does not represent an authoritative resolution of the informed consent debate. The underlying issues raised by questions regarding pre-treatment advice are universally recognised, as is the basic premise that the patient has a right to sufficient information to make an 'intelligent' or 'informed' decision. What is contested, or at variance, between the different jurisdictions within the United States (and as we shall see in following Chapters, other jurisdictions), is the actual content of the disclosure and the test for determining what constitutes

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<sup>42</sup> In the United States there is both a „patient centred“ and a „professional standard“ test, both of which will be discussed in detail below.

<sup>43</sup> This section of the discussion was informed by a broad review of decisions across jurisdictions in the United States. These included: *Blazoski v Cook* (2002) 346 NJ Super 256 (superior Court of New Jersey), *Caputa v Antiles* (1996) 296 N.J. Super.123 (Superior Court of New Jersey), *Carr vStrode* (1995) 904 P.2d 489 (SC Hawai'i), *Cobbs v Grant* (1972) 8 Cal.3d 229, *Daum v Spinecare Medical Group Inc* (1997) 52 Cal. App.4<sup>th</sup> 1285 (Court of Appeal, first District, Division 3, California), *Duttry v Patterson* (2001) 565 Pa. 130. (SC of Pennsylvania), *Duttry v Patterson* (2001) 565 Pa. 130. (SC of Pennsylvania), *Foote v Rajadhyax* (2000) 268 A.D.2d 745 (SC, Appellate Division, NY), *Giese v Stice* (1997) 252 Neb. 913 (SC of Nebraska), *Gorab v Zook* (1997) 943 P.2d 423 (SC of Colorado), *Guidry v Neu* (1997) 708 So.2d 740 (Court of Appeal, Louisiana), *Harrison v United States of America* (2002) 284 F.3d.293 (United States Court of Appeals, First Circuit), *Howard v University of Medicine & Dentistry of NJ* (2002) 172 NJ 537, *Hyles v Cockrill* (1983) 169 Ga. App. 132, *Jamison v Kilgore* (2004) 905 So. 2d 610 (Court of Appeals Mississippi), *Karp v Cooley* (1974) 493 F.2d 408, *Ketchup v Howard* (2000) 247 Ga.App. 54 (Court of Appeals of Georgia), *Largey v Rothman* (1988) 110 N.J. 204 (SC of New Jersey), *Martin v Richards* 192 Wis.2d 156 (1995), *Matthies v Mastro Monaco* (1999) 160 N.J. 26 (SC of New Jersey), *Natanson v Kline* 186 Kan. 393 (1960), *Pope v Davis* (2003) 261 Ga. App. 308 (Court of Appeals, Georgia), *Quintanilla v Dunkelmann* 133 Cal. App. 4<sup>th</sup> 95 (2005) (Court of Appeal, Second District, Div.5 California), *Retkwa v Orentreich* (1992) 154 Misc. 2d 164 (Sc of NY County, NY), *Salgo v Leland Stanford Jr University Board of Trustees* (1957) 317 P.2d 170, *Schreiber v Physicians Ins. Co.* 588 N.W.2d 26 (Wis 1999).

<sup>44</sup> For reference to *Canterbury* as a „landmark“ decision see *inter alia*, J.W. Berg, P.S. Appelbaum, C.W. Lidz, L.S. Parker, *Informed Consent: Legal Theory and Clinical Practice* (2<sup>nd</sup> ed, Oxford University Press, New York, 2001), 65, Barbara L. Atwell, „The Modern Age of Informed Consent,“ (2006) 40 *University of Richmond Law Review* 591, 596, J.L. Hale, G.R. Podell „Medical Malpractice in New York“ (1976) 27 *Syracuse L. Rev* 657, 732, Arnold J. Rosoff, *Informed Consent* (Rockville, Aspen, 1981), 38, R.R. Faden, T.L. Beauchamp., (with Nancy King), *A History and Theory of Informed Consent* (Oxford University Press, New York, 1986), 133 and *Rosenberg v Percival* (2001) 205 CLR 434, [105] (Kirby J).

an appropriate level of information. It is important to remember that the *Canterbury* test is, in fact, adopted by less than 50% of the States.<sup>45</sup>

Before the test for standard of care is analysed, it is helpful to turn one's mind to the underlying problem that the Courts, when considering standard, are attempting to solve. A good starting point is to consider why the level of information due to a patient is even open to debate. We can take this one step further and ask why the informational needs of the patient are not routinely met? Close analysis of the decisions suggest that the problems can be attributed to certain underlying 'certainties' that have been accepted by the judiciary and remain unchallenged by either patients or physicians.<sup>46</sup> These certainties were clearly stated by the Court in *Cobbs v Grant*:<sup>47</sup>

1. the knowledge of the patient and physician are not in parity,
2. a person of adult years and sound mind has the right to exercise control over their own body to determine whether or not to submit to lawful medical treatment,
3. for patient consent to treatment to be effective it must be informed, and
4. the patient, being unlearned in medical sciences, has an abject dependence upon and trust in his physician for the information upon which he relies in making a decision.<sup>48</sup>

The aim of the Courts is therefore to bridge the power-and-knowledge gap between the physician and patient and ensure that the patient is 'informed.' But can this be achieved and, if so, what is the appropriate yardstick? Do we

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<sup>45</sup> L.B.Frantz, above n.14, and W. Berg, P.S. Appelbaum, C.W. Lidz, L.S. Parker, *Informed Consent: Legal Theory and Clinical Practice* (2<sup>nd</sup> ed, Oxford University Press, New York, 2001), 48 notes the reversal in the trend set by *Canterbury* and the split in the approach in the Courts in the United States whilst R.R.Faden, T.L.Beauchamp, (with Nancy King), *A History and Theory of Informed Consent* (Oxford University Press, New York, 1986), 139 tracks the decline of the *Canterbury* approach.

<sup>46</sup> These „certainties“ form the basis of decisions not only in the United States but can also be seen to underpin the decisions in Australia and the United Kingdom, as will become evident in jurisdiction specific discussion to follow.

<sup>47</sup> *Cobbs v Grant* 8 Cal. 3d 229 (1972).

<sup>48</sup> *Ibid*, 242 (Mosk J), I have set these out as a list for clarity, in the judgment His Honour describes these „postulates employed by judges“ and the words are essentially his.

look to the patient to determine what information they would have deemed appropriate or is it best left to the knowledge and skill of the doctor? If it is the doctor who is to decide what information the patient needs, how can this be reconciled with the purported role of informed consent which is to protect the individual needs of the autonomous patient? We can see therefore that even at this most basic stage of the enquiry the Courts struggle to establish the appropriate focus. If we are to unravel the complexities and establish a coherent doctrine of 'choice' we must carefully consider the existing tests for 'informed consent' and ascertain their efficacy. *Canterbury* is indeed a 'landmark' decision yet both Courts and legislatures in the United States have retreated from the position adopted by the *Canterbury* Court. As a result of this retreat we have, in the United States (and indeed around the world), a clear distinction between the patient-centred or materiality test and the professional practice test. As we shall see below, however, the differences tend to be purely linguistic and the practical outcomes are remarkably similar, a point that Sally will help make abundantly clear in the concluding discussions of Part I of this thesis.

#### **Patient centred, materiality test**

[2.40] The patient-centred test begins from the perspective of the patient and seeks to determine what information would have been material to the decision-making process of either that particular patient (a subjective test not widely adopted) or, more commonly, the reasonable patient in that position. The central theme introduced in *Canterbury* and adopted by many Courts, is materiality, a concept driven not by professional practice, but solely by what the patient wants and needs to know (or ought to want and need). The adoption of materiality as a decisive factor is a common theme running through the decisions purporting to apply *Canterbury*.

The Supreme Court of New Jersey, for example, embraced the decision in *Canterbury*, describing it as introducing a new standard resting on materiality.<sup>49</sup> This is a telling decision as the Court emphasised the underlying rationale of the rejection of the professional standard, citing, *inter alia*: the absence of a discernable custom reflecting medical consensus, the imperative of non-medical factors such as emotional condition, inconsistency with the right to self-determination and the difficulty of patient access to supporting expert testimony (the risk of the professional ‘conspiracy of silence’).<sup>50</sup> Each of these factors were described as supporting the rejection of the professional standard and the return of the decisional power to the patient.

The view of *Canterbury* as a significant protector of patient self-determination is one repeated throughout judicial consideration of the issue. It has been described as adopting the materiality standard to protect the patient’s right to self-determination,<sup>51</sup> and spearheading what has become known as the patient-oriented standard.<sup>52</sup> Significantly, *Canterbury* has come to represent protection of self-determination by directing Courts to look to the motivating force of the doctrine of informed consent – protection of the autonomous patient.<sup>53</sup> For those decisions basing their reasoning on an interpretation of *Canterbury*, the cautionary note<sup>54</sup> is ignored and informed consent is viewed as the core principle. The reason for the rejection of the ‘informed consent’ terminology by Robinson J (in *Canterbury v Spence*) was that in his view,

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<sup>49</sup> Refer *Largey v Rothman* 110 N.J. 204 (1988).

<sup>50</sup> *Ibid*, 213.

<sup>51</sup> *Retkwa v Orentreich* 154 Misc. 2d 164 (1992).

<sup>52</sup> *Carr v Strode* 904 P.2d 489 (1995)(Supreme Court Hawai’i).

<sup>53</sup> *Ibid*, 499. Also note *Harrison v United States of America* 284 F.3d. 293, in which the Court describes the „very purpose of disclosure“ as being protection of autonomy, (298), in *Carr v Strode* (1995) 904 P.2d 489 self-determination was described as the „motivating force and purpose of the doctrine of informed consent“ (499), *Daum v Spinecare Medical Group Inc* (1997) 52 Cal. App.4<sup>th</sup> 1285 saw the Court exploring the „cardinal principle which guides the Courts“ (self-determination) (1304), whilst in *Largey v Rothman* (1988) 110 N.J. 204 the Court chose to abandon the professional standard describing it as, „*inter alia*, inconsistent with the patient’s right of self-determination“ (213), *Howard v University of Medicine & Dentistry of NJ* (2002) 172 NJ 537 explained that the „patient-centred view of informed consent stresses the patients“ right to self-determination“ (547) and in *Natanson v Kline* 186 Kan. 393 (1960) the Court stated that „Anglo-American law starts with the premise of thorough-going self-determination“ (407).

<sup>54</sup> Refer *Canterbury v Spence* 464 F. 2d 772, (1972) at 780, fn15, where the Court rejects the term informed consent as unhelpful.

'informed consent' misdirects the enquiry and 'implies that what is decisive is the degree of the patient's comprehension.'<sup>55</sup> It was the view of the *Canterbury* Court (a view supported in subsequent decisions) that it is not a question of patient comprehension. Additionally, the quality of the information given is not a key concern. Rather the focus is on content. This is not entirely consistent with a patient-centred enquiry.

With the emphasis on such ideals as self-determination and autonomy in the evolution of the materiality test, there is a stated aim of returning the decision-making power to the patient. This is deemed to be the central concern not only in the United States, but as we shall see in the following Chapters, in all of the jurisdictions under consideration. Interestingly, however, despite the impetus for the enquiry being the return of authority to the patient, it becomes irrelevant when the Courts turn their attention to the identification of the measurement of the loss sustained. The loss of decision-making power which flows from incomplete pre-treatment information is ignored. What we see is an enquiry which starts with the foundational premise of a patient's right to information: in jurisdictions which apply the patient-centred materiality test this right is given content through an exploration of what the patient would deem material. But the loss then becomes a physical one. There is a gap in reasoning here that the Courts struggle to bridge as there is not always a clear causative link between the denial of information and the manifestation of a physical harm.<sup>56</sup>

The gap between the apparent aim of informed consent and the practical application of the doctrine becomes even more problematic when the right of the patient to information is measured not by the expectations or needs of the

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<sup>55</sup> Ibid.

<sup>56</sup> This gap is investigated in detail in Part II which explores the role of causation, it will then be specifically addressed when we consider an alternative to the current model of loss in Part III and the concluding discussion.



patient but by the professional expertise of the doctor. This is the situation in the United Kingdom<sup>57</sup> and parts of the United States.

### **The professional practice test**

[2.50] In some instances in the United States, the Courts have purported to reject the patient centred approach embodied in the *Canterbury* decision. Yet the enquiry continues to spring from the 'root premise' of *Schloendorff* that 'every human being of adult years and sound mind has a right to determine what shall be done with his own body.'<sup>58</sup> Importantly, the nature of consent turns on the provision of information enabling a knowledgeable evaluation of the options available and the risks attendant upon each.<sup>59</sup> The point of departure from the materiality test is the source of evidence and the question of who is to determine what constitutes sufficient information. In Texas, for example, it is described as a medical standard to be proved by medical experts, focussing on the reasonable practitioner, with the correct question being not what the reasonable juror or the reasonable man would relate, but what the 'reasonable practitioner' would relate.<sup>60</sup>

The professional practice standard is most commonly embodied in statute mandating its adoption by the Court. This does not always sit comfortably with the judiciary. The decision in *Eccleston v Chait*,<sup>61</sup> provides an excellent example with the professional standard (as opposed to the more patient centred material risk standard), being described as paternalistic,<sup>62</sup> resulting in the patient being left in the 'precarious position' of having to explore the risks and adverse consequences themselves.<sup>63</sup>

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<sup>57</sup> To be discussed in Chapter 3.

<sup>58</sup> *Karp v Cooley* 493 F.2d 408 (1974), 415 (Bell J, citing *Schloendorff v The Society of the New York Hospital* 211 N.Y 125 at 129-130, (1914)).

<sup>59</sup> *Ibid*, 419.

<sup>60</sup> *Ibid*, 420.

<sup>61</sup> *Eccleston v Chait* 241 Neb. 961 (SC Nebraska) (1992).

<sup>62</sup> *Ibid*, 968.

<sup>63</sup> *Ibid*, 969.

As a result of this discomfort, the Courts have tended to struggle with the application of a standard that is viewed as potentially in conflict with the foundations thought to be laid by decisions such as *Schloendorff* and *Canterbury*. The Courts strive to preserve the autonomy of the patient in a climate viewed as being controlled by the medical profession.<sup>64</sup> The Court in *Retkwa*,<sup>65</sup> for example, took care to explore the materiality standard as explained in *Canterbury v Spence* and interpreted it as protecting the patient's right to self-determination<sup>66</sup> and therefore consistent with the aims of *Schloendorff*. However the Court was bound by the implementation of legislation requiring that informed consent be measured not by what a reasonable patient would want or need to know, but by what a competent physician believes the patient in his or her circumstances ought to know. Thus the appropriate standard was to be determined with reference to expert evidence but the enquiry must continue to be driven by the underlying right of the patient to determine whether or not to undergo a particular course of treatment.<sup>67</sup> Similarly, the more recent decision of *Foote v Rajadhyax*<sup>68</sup> grounds the test in what a reasonable medical practitioner would have disclosed along with what the reasonably prudent patient would have decided to do.<sup>69</sup>

It is perhaps this struggle to have due regard to the prudent/reasonable patient within the constraints of the professional practice standard that has led to the emergence of a hybrid test which uses the language of the professional practice standard but, at times directly, addresses the concepts of materiality and the prudent patient. The waters have become muddied by this preoccupation with the appropriate measure of standard and the enquiry complicated by the perceived need to combine two, potentially conflicting,

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<sup>64</sup> The Court in *Retkwa v Orentreich* 154 Misc. 2d 164 (1992) describes the implementation of legislation as being driven by threats of strike action following *Canterbury v Spence* 464 F.2d 772, (1972).

<sup>65</sup> *Ibid.*

<sup>66</sup> *Ibid.*, 166.

<sup>67</sup> *Ibid.*, 168.

<sup>68</sup> *Foote v Rajadhyax* (2000) 268 A.D. 2d 745.

<sup>69</sup> *Ibid.*, at 745.

approaches. Interestingly, whatever approach is adopted, breach of duty is the most common conclusion.

### *The scholarly view of Canterbury*

[2.60] With the apparent acceptance by the Courts of the autonomous, self-determining patient, it would perhaps be reasonable to assume that the doctrine of informed consent can be clearly identified and analysed. This is not the case. There are repeated references throughout the scholarly literature to the inherent uncertainty of the doctrine along with a recognition that the Courts are endeavouring to balance competing needs that may not be reconcilable. For example, Faden and Beauchamp describe the doctrine and underlying theory as 'strikingly unsettled'<sup>70</sup> and suggest that this 'uncertainty ... has hindered the understanding of informed consent since its earliest development,'<sup>71</sup> whilst Berg et al explore the confusion that continues to exist about the requirement of the informed consent doctrine<sup>72</sup> and suggest that the 'legal requirements of the doctrine remain unclear.'<sup>73</sup> Katz is a little more scathing in his description of the doctrine, highlighting the 'problem of uncertainty of the doctrine' and suggesting that 'informed consent is a charade'<sup>74</sup> and in a similar vein Heinemann talks of the 'residual doubts' left by *Canterbury* and goes so far as to suggest that 'it undermined the ideal of self-determination.'<sup>75</sup> Still others say that it is 'either functionally symbolic or dysfunctionally sentimental'<sup>76</sup> and 'laudable in theory, but not a panacea.'<sup>77</sup> In short, neither *Canterbury* nor the doctrine of informed consent are

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<sup>70</sup> R.R. Faden and T.L. Beauchamp (with Nancy King), *A History and Theory of Informed Consent* (Oxford University Press, New York, 1986), 115.

<sup>71</sup> *Ibid*, 116.

<sup>72</sup> J.W. Berg, P.S. Appelbaum, C.W. Lidz, L.S. Parker, *Informed Consent: Legal Theory and Clinical Practice* (2<sup>nd</sup> ed, Oxford University Press, New York, 2001), 45.

<sup>73</sup> *Ibid*, 65.

<sup>74</sup> J. Katz, „Informed Consent, Must it Remain a Fairytale“ (1994) 10 *Journal of Contemporary Health Law and Policy* 69, 81.

<sup>75</sup> R.A. Heinemann, „Pushing the Limits of Informed Consent: Johnson v Kokemoor and Physician- Specific Disclosure,“ (1997) *Wisconsin Law Review* 1079, 1085.

<sup>76</sup> K. M. Boos, E. J. Boos, „At the Intersection of Law and Morality: A Descriptive Sociology of the Effectiveness of Informed Consent Law,“ (2004) 5 *Journal of Law in Society* 457, 464.

<sup>77</sup> B. L. Atwell, „The Modern Age of Informed Consent,“ (2006) 40 *University of Richmond Law Review*, 591, 598.

embraced as clear or certain. There is, however, one common thread and this is the ready acceptance of the concept of a doctrine of informed consent striving to protect patient autonomy,<sup>78</sup> a concept which, close analysis reveals, was challenged by the *Canterbury* Court.

As outlined above, the common starting point for considerations of *Canterbury* is a discussion of autonomy with the recognised goal of 'informed consent' being 'to obtain a morally valid consent' based on appropriate provision of information.<sup>79</sup> The traditional position of informed consent, hinging upon the notion of autonomy, is widely recognised<sup>80</sup> as are the difficulties often encountered by the Courts when they have sought to adhere to this apparently foundational premise. The various judicial appeals to autonomy have been described as 'blundering' and 'confused,'<sup>81</sup> clearly reflecting the practical difficulty of uniform application of a concept which is not uniformly defined.<sup>82</sup> The problem of focussing on the mechanics of information giving without testing patient understanding has also been highlighted.<sup>83</sup> This gap between information and understanding (which was specifically identified as valid by the *Canterbury* Court<sup>84</sup>) poses an obstacle to truly informed decision making, and therefore to autonomy. The enquiry is

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<sup>78</sup> A significant problem with the concept of autonomy is the imprecise meaning of the term, this is explored in detail in Part III, Chapter 10. For reference to the significance of self-determination and autonomy refer (for example), Faden et al, above n.70, 135 where self-determination is described as providing the *Canterbury* Court with its primary justification," Frantz, above n.14, §2b where the „very basis“ of the informed consent theory is to protect the patient's right to choose what is done to their body. Boos and Boos, above n.76, 468 claim that „informed consent hinges on autonomy“ Suzanne K. Ketler, „The Rebirth of Informed Consent: A Cultural Analysis of the Informed Consent Doctrine after *Schreiber v Physicians Insurance of Wisconsin*,“ (2001) 95 *Northwestern University Law Review* 1029 explains that the common law doctrine of informed consent is premised upon the principle of bodily self-determination“ and Atwell, above n.77, 596 asserts that „autonomy is the fundamental principle ... a fundamental part of our legal fabric.“

<sup>79</sup> G.P. Smith „The Vagaries of Informed Consent“ (2004) 1 *Indiana Health Law Review* 111, 112. See also the references and comments outlined *ibid*.

<sup>80</sup> A.D. Burnett III, „Suturing the Loophole: Informed Consent as a Requirement for Procedures not Enumerated in Pennsylvania's Medical Informed Consent Statute,“ (2004) 108 *Penn State Law Review* 1249,1263, Boos and Boos, above n.76, 469 Atwell, above n.77, 594.

<sup>81</sup> Faden, et al, above n.70 , 141.

<sup>82</sup> Boos and Boos, above n. 76, 469 for example highlights the point that as the concept of autonomy is variously defined, it creates an uncertain basis upon which to rest a foundational doctrine. As mentioned above, this issue is discussed in more detail in Part III, Chapter 10.

<sup>83</sup> Cathy J. Jones, „Autonomy and Informed Consent in Medical Decision-making: Toward a New Self-Fulfilling Prophecy“ (1990) 47 *Washington and Lee Law Review* 379, 392.

<sup>84</sup> Refer *Canterbury v Spence* 464 F.2d 772, (1972), 779.

guided by considerations of professional standards, not patient needs and rights.

It has been suggested that the rationale of *Canterbury* is based upon a flawed assumption.<sup>85</sup> The decision is therefore not routinely endorsed. As we have seen, one of the most significant criticisms of the decision is its lack of certainty and efficacy. Within the scholarly literature there is a recognition that the richness of law's 'rhetorical devotion to the ideal of patient self determination' is not equalled by a willingness to provide effective legal redress to patients who have a grievance. This is a theme that I will develop further throughout this thesis and in Chapters 3 and 4 we will see that this is also a concern in both the United Kingdom and Australia. In short, the existing doctrine presents some difficulties to the scholars who have considered it and the practical application of informed consent as exemplified by *Canterbury* has been described as 'far from perfect,'<sup>86</sup> 'a façade'<sup>87</sup> and 'inadequate.'<sup>88</sup>

One objection to *Canterbury* decision is the apparent lack of certainty attached to the concept of materiality and the questionable basis of the reasoning of the Court. It has been suggested that the rationale of *Canterbury* is based upon a flawed assumption and involved the Court simply 'grafting' the patient's interests and the physician's duties together.<sup>89</sup> The identified flaw being the assumption that the patient's personal choice and the physician's commitment to their professional duty 'tend generally to the same end.'<sup>90</sup> In reality, these two duties may coincidentally align but this will not always be the case. To preserve a patient's right of self-determination by specifying the physician's standard of care (as was done by the *Canterbury* Court), is to

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<sup>85</sup> A.J. Wiesbard, „Informed Consent: The Law's uneasy Compromise with Ethical Theory,“ (1986) 65 *Nebraska Law Review* 749, 751.

<sup>86</sup> Atwell, above n.77, 598.

<sup>87</sup> Schuck, P.H, „Rethinking Informed Consent,“ (1994) 103 *Yale Law Journal* 899, 904.

<sup>88</sup> Atwell, above n.77, 598.

<sup>89</sup> Faden, Beauchamp (Nancy King), above n.20, 135.

<sup>90</sup> *Ibid.*

obscure the different nature of physician and patient rights and duties. In the blurring of the lines between rights and duties we see the beginning of a problem which is apparent in all stages of the informed consent analysis. There is a foundational premise of the patient's right to adequate disclosure and a stated intention to protect this right. Yet there is a significant divide between the protected right and the measure of appropriate standard of care. The Courts emphasise autonomy and begin with a clear focus on the patient, yet in the practical application of the legal test, they immediately shift focus from the patient to the doctor. Very quickly we see autonomy give way to considerations of accepted (and expected) medical standards. Thus, one person's right is measured by another's duties.<sup>91</sup> Whilst this could be described as a clear example of Hohfeld's 'jural correlatives'<sup>92</sup> with the 'right' of the patient being defined and explored by the doctor's correlative duty, it diminishes the significance of the patient's perspective and the existence of a relationship, choosing to focus instead entirely on the expected standards of the doctor. Thus the correlative nature of the relationship is overlooked beyond the initial recognition of the two parties with the enquiry focussing entirely on one side of the relationship.

The *Canterbury* Court is most generally associated with the adoption of the patient-centred test and rejection of the professional standard as unduly deferential to the medical profession,<sup>93</sup> but this is not the only interpretation of the decision. The endorsement of therapeutic privilege<sup>94</sup> along with an objective standard driven by what the physician believes a reasonable patient would consider material (as opposed to the actual patient before him or her), has supported an interpretation that it is a decision 'typifying the reluctance

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<sup>91</sup> This is a theme also raised by Sheila A.M. McLean, see *A patient's right to know: Information disclosure, the doctor and the law* (Dartmouth Publishing Company, Aldershot, 1989), 87 and *Autonomy, Consent and the Law* (Routledge-Cavendish, New York, 2010), 72.

<sup>92</sup> W.N. Hohfeld, *Fundamental Legal Conceptions* (Yale university Press, Newhaven, 1964), 36 ff.

<sup>93</sup> This description is one that the *Canterbury* Court itself would favour, refer *Canterbury v Spence* 464 F.2d 772, (1972), 784.

<sup>94</sup> That is, the endorsement of the withholding of information on the grounds that „it poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view“ *Canterbury v Spence* 464 F.2d 772, (1972), 789.

of judges to impinge on the authority and expertise of medical practitioners.<sup>95</sup> A further criticism levelled at the *Canterbury* decision is that its 'legacy is as much the consent form' as it is clarity and awareness of the patient's rights.<sup>96</sup>

The endeavours of the *Canterbury* Court are not, however, universally criticised. The case has been described as the landmark case providing a touchstone for informed consent<sup>97</sup> 'presenting a modern, comprehensive and focal paradigm of the legal concept of informed consent in application.'<sup>98</sup> It has been recognised as establishing a 'far-reaching patient-centred standard of disclosure,'<sup>99</sup> 'based upon a foundation of bodily integrity.'<sup>100</sup> Indeed, it is this foundational principle which is most frequently emphasised as emanating from the heart of the *Canterbury* decision. Despite this support, it is clear that there are problems with the realisation of the ideal of *Canterbury* and it is to these problems we must now turn.

### **The practical application of *Canterbury* and the emergence of a hybrid test**

[2.70] Scholarly consideration of *Canterbury* has been quick to highlight the shortcomings of an ideal based upon patient autonomy, but Courts have been reluctant to abandon this ideal. The realities of practice, however, have meant that informed consent in the United States is purportedly represented by two distinct standards: the professional standard and the patient-centred standard. Careful consideration of the different judgments, however, demonstrates that the two interests have merged to create a hybrid standard endeavouring to protect both the physician and the patient. This hybrid standard pays deference to the autonomous patient at the same time as

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<sup>95</sup> Richard A. Heinemann, „Pushing the Limits of Informed Consent: Johnson v Kokemoor and Physician- Specific Disclosure,“ (1997) *Wisconsin Law Review* 1079, 1086.

<sup>96</sup> *Ibid.*

<sup>97</sup> See for example: Atwell, above n.79, 596, A.R. Rosoff, *Informed Consent* (Rockville, Aspen, 1981), 38 and G.P. Smith, above n.79, 117. See also the references to *Canterbury* as a „landmark“ decision as outlined above n.44.

<sup>98</sup> G. P. Smith, above n.79, 117.

<sup>99</sup> Boos and Boos, above n.76, 473.

<sup>100</sup> Burnett, above n.80, 1262.

turning to the profession for advice. Once again we see Courts trying to reconcile interests which even in an ideal doctor/patient relationship are unlikely to be reconcilable.

A clear example of the hybrid standard is found in *Cobbs v Grant*<sup>101</sup> which begins from the position that the physician must reveal to the patient such additional information as a 'skilled practitioner of good standing would provide under similar circumstances.'<sup>102</sup> The Court then summarises its position by describing the right of self-decision as the measure of the physicians' duty to reveal and then affirms the concept of intelligent choice and the *Canterbury* idea of materiality.<sup>103</sup> The Court concludes by handing discretion back to the physician with the strong statement that a disclosure beyond that required by the medical community is not necessary when it can be demonstrated that such a disclosure would have meant that the patient was unable to 'dispassionately weigh the risks of refusing to undergo the treatment.'<sup>104</sup> Thus the Court is advocating the 'protection' of the patient through the withholding of information which would only serve to colour their reasoning and perhaps, lead to a decision that is in contrary to the accepted medical opinion. We see therefore the use of the language of self-determination alongside a clear deference to professional opinion, with the reasoning leaving open the question of how or when a patient can ever be described as 'dispassionate.' Surely, the personal nature of the decision-making process, in the context of medical treatment means that it is, by its very nature, a deeply personal and 'passionate' process? Thus we see that despite the steps taken by the Court to lend clarity to the debate, they have simply raised another set of questions.

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<sup>101</sup> 8 Cal.3d 229, (1972).

<sup>102</sup> Ibid, 244-5 (Mosk J).

<sup>103</sup> Ibid, 245. The concept of an intelligent decision is not defined in any of the case law that employs the term, once again leaving a definitional gap.

<sup>104</sup> Ibid, 246.



The hybrid standard reflects an attempt by the Courts to balance individual needs and rights against the social utility of a medical profession that can confidently operate without constant fear of litigation. In Colorado the balance was struck by recognising the need to inform patients of ‘medically significant risks.’<sup>105</sup> However whether or not a risk was deemed to meet this requirement had to be demonstrated by expert testimony.<sup>106</sup> The test of significance or materiality was removed from the patient and returned to the profession. A final example (for present purposes) of the hybrid test is found in *Ketchup v Howard*<sup>107</sup> when the Court acknowledged the requirement of material risk and claimed that all states had a doctrine of informed consent embodying this concept.<sup>108</sup> The Court then neatly straddled the divide of the two, apparently competing, standards by referring to the American Medical Association (AMA) Code of Medical Ethics which provides at s 8.08 that: ‘[t]he patient’s right of self-decision can be effectively exercised only if the patient possessed enough information to enable an intelligent choice.’<sup>109</sup>

The view of the Court in this instance was that because the AMA is an organisation composed of medical experts, its code of ethics should be understood to reflect the professional standard of care,<sup>110</sup> therefore the patient and professional standards are to be viewed as one. It is worth noting the use of the term ‘choice’ here. Clearly it is recognised as an important component of the informed consent process and the language of choice is deemed appropriate by the AMA, yet choice is generally overlooked in favour of the term consent. We will of course explore this further in Part III in our journey towards a legal recognition of informed choice as opposed to informed consent.

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<sup>105</sup> *Gorab v Zook* 943 P.2d 423 (1997), 427.

<sup>106</sup> *Ibid.*

<sup>107</sup> 247 Ga.App 54 (2000).

<sup>108</sup> *Ibid.*, 54 (Johnson CJ).

<sup>109</sup> AMA Website, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.shtml>, at January 2011.

<sup>110</sup> *Ketchup v Howard* 247 Ga. App 54 (2000), 60 (Johnson CJ). The Court was referring to an earlier version of the AMA Code but the point continues to be relevant in this context and retains the same provision.

These examples of judicial linking of two ideals (professional standard and protection of autonomy through a more patient-centred test) are overly optimistic and fail to appreciate the complex clash of expectations. In reality, a test has evolved that endeavours to protect the physician from liability. It has even been suggested that the disclosure practices changed not to protect the autonomous patient, but to assist doctors to escape liability.<sup>111</sup> This interpretation is further strengthened by the strong assertion by Ketler in 2001 that the legal doctrine of informed consent is concerned with how much and what kinds of information physicians must provide to their patients in order to avoid legal liability, while also suggesting that the common law doctrine of informed consent is premised upon the principle of bodily self-determination.<sup>112</sup> This description is inherently contradictory and demonstrates inconsistency in application of the doctrine. How can a doctrine which is given effect by protecting physicians from liability be described as protecting a patient's bodily self-determination? This is a core problem with the practical application of the *Canterbury* principle which does not match its stated aims. And this is a problem which we will observe in each jurisdiction under consideration.

A further problem with the application of informed consent in the United States is the fact that despite the different tests, there is little practical difference in the application of the different standards. Berg et al<sup>113</sup> refer to a comparative study of states employing the professional standard versus those focussing on the 'materiality' or more patient-centred approach. The study found no significant difference between physician disclosures.<sup>114</sup> Therefore after much debate, many assertions and conclusions it would appear that

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<sup>111</sup> J.Katz, „Informed Consent – Must it Remain a Fairytale?“ (1994) 10 *Journal of Contemporary Health Law & Policy* 69, 80-81.

<sup>112</sup> Suzanne K. Ketler, „The Rebirth of Informed Consent: A Cultural Analysis of the Informed Consent Doctrine After *Schreiber v Physicians Insurance of Wisconsin*,“ (2001) 95 *Northwestern University Law Review*, 1029, 1032 and 1035).

<sup>113</sup> Berg et al, above n.72 referring to A. Rosoff, A.R. Rosoff, *Informed Consent* (Rockville, Aspen, 1981).

<sup>114</sup> *Ibid*, 52.

there is no difference between the practical outcomes of the purportedly divergent tests.

More than 30 years on, what then does *Canterbury* represent? The practical realisation of the decision appears to be a standard difficult to both define and apply in the clinical setting. Not only are the standards unclear, but in reality they are often viewed as the means of instructing juries about professional standards rather than protecting patients or informing physicians.<sup>115</sup> Once again we see the recurring issue of measuring the rights of one party through the analysis of the duties of another. Whilst duties and rights are, by their nature, correlative, here the correlation is present in name only. The Courts refer to the right of the patient to information and the duty of the doctor to provide it. The nature of the duty then transforms into a *professional* duty to act in accordance with *professional* standards. The result of this approach is a displacement of the autonomous patient from the discussion as their rights are not a practical consideration. This conclusion is one which will echo throughout our discussion and we will see that it is a concern that is repeatedly raised in judicial and scholarly considerations of pre-treatment advice.

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<sup>115</sup> Ibid, 64.

## Re-visiting the core issues

[2.80] In the introductory discussion I posed three questions that will be addressed in each of the Chapters of this Part of the thesis. The preceding discussion implicitly answered each of those questions but before moving on to the discussion of the position in the United Kingdom (and then of course of Australia), each of the questions will be specifically addressed, thus providing a clear end to this stage of our discussion.

### *Is 'informed consent' truly about consent?*

[2.90] Robinson J in *Canterbury* asserted that 'true consent comes from the *informed exercise of a choice* and the ability to evaluate knowledgeably the options available.'<sup>116</sup> Alongside this, however, he cautioned that the test is not truly about consent and emphasised that consent and the provision of information are 'two sides of the same coin' but to label inquiries such as those outlined here as being about consent is a 'misdirection.'<sup>117</sup> Analysis of the informed consent doctrine is therefore not truly about consent but about patient rights to information and the doctor's professional duty to provide that information. Consent is best left to discussions of trespass.

### *Who takes the central role (the prudent patient or the prudent professional)?*

[2.100] As we have seen, the position in the United States is often interpreted as being patient centred as represented by *Canterbury*. Such an interpretation entails a misunderstanding (and over simplification) of the actual position as stated by the Courts. The approach in the United States is not consistent across the jurisdictions and even the apparently patient-centred enquiries involve clear consideration of professional standards. In addition to the mix

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<sup>116</sup> *Canterbury v Spence* 464 F.2d 772, (1972), 779, (emphasis added).

<sup>117</sup> *Ibid*, 780 refer fn 15 of the judgment.

of considerations, there has been an attempt to reconcile the interests of both the doctor and the patient which has resulted in the development of a hybrid test representing both the doctor and the patient. It is also important to remember that whilst *Canterbury* is viewed as rejecting the professional standard, the Court acknowledged the significance of the expertise of the physician and suggested that the test is not about the patients' comprehension or consent but it is about the physician's provision of information and their duty to 'enlighten' the patient.<sup>118</sup>

A further important aspect of the *Canterbury* decision is the evidentiary role played by professional practice along with the fact that the so-called patient-centred test of materiality begins with a consideration of the views of the physician.<sup>119</sup> Beyond *Canterbury*, both patient and professional-centred tests are applied and the reality is that similar language is employed in both discussions and often elements of the other creep in, thus we have a hybrid test.<sup>120</sup>

*Are we dealing with patient autonomy or professional standard of care? (Or is it about the doctor or the patient?)*

[2.110] This question addresses the main issue at the duty stage of the enquiry. The purported driving force of the doctrine is patient autonomy<sup>121</sup> and yet the actual patient does not always factor in the judicial discussions. As outlined above, even *Canterbury*, which purports to focus on the patient, marks a retreat from the patient. The focus is on the actions of the doctor. There is a perceived conflict between the needs and expectations of the patient and the role of the doctor as a professional. We see in *Canterbury* an ostensible recognition of the significance of the actual patient, but the 'patient-centred' materiality test begins from the perspective of the doctor. By

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<sup>118</sup> Ibid.

<sup>119</sup> Ibid, 786.

<sup>120</sup> For references to support this assertion, refer above n.43.

<sup>121</sup> See discussion and references above n.53

contrast, in *Retkwa v Orentreich*<sup>122</sup> we see the opposite happen, when a Court bound by statute to apply a professional standard begins from the position of the rights of the patient, while *Foot v Rahadhyax* endeavours to straddle both considerations by holding that the question must be addressed by determining what a reasonable medical practitioner would have disclosed along with what the reasonably prudent patient would have decided to do.<sup>123</sup>

The answer to the three questions posed is therefore neither clear nor straightforward. It is upon this uncertain foundation that the entire doctrine of informed consent sits. We will now turn to the United Kingdom which purports to employ a pure professional test and discover that similar considerations guide the decisions of the English Courts. As we progress through this analysis it will become increasingly evident that we have a complex doctrine that purports to protect a foundational right of the patient but fails to do so with any consistency. Perhaps this is because the wrong question is being asked. The enquiry is framed around the issue of consent when the matter is really about the communication between a doctor and their patient and the resulting process of making a choice. This is the argument at the heart of my thesis and it is an argument that is further developed in Chapter 3 where we consider the United Kingdom.

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<sup>122</sup> *Retkwa v Orentreich* 154 Misc. 2d 164 (1992).

<sup>123</sup> *Ibid*, at 745.

## Chapter 3: The United Kingdom<sup>1</sup>

### Introduction

[3.10] This Chapter provides a perfect contrast to the last as we move our attention to a test for standard of care purportedly based upon professional practice as opposed to patient expectations. In the United Kingdom we find a test with an apparently different focus from that of the United States. Despite the fact that some Law Lords have expressed sympathy for the position in the United States,<sup>2</sup> there has been a clear and consistent rejection of the notion of informed consent. The test of sufficiency of information prior to receipt of treatment is closely identified with professional standards, determined by ‘responsible’ members of the profession. In establishing the appropriate standard of care the patient is removed from contemplation (they do not re-enter the arena until the causation stage), with the doctor and his/her peers taking centre stage.

This description of the position in the UK is the traditional one and relies upon a received interpretation of the two leading decisions of *Bolam* and *Sidaway*.<sup>3</sup> The traditional interpretation is, however, open to challenge, with more recent decisions and discussions questioning the original aims of McNair J in *Bolam* and the subsequent broad application of his words. With the apparent demise of informed consent in the United Kingdom, it has been argued that the Courts have abrogated their authority to the medical profession, allowing those who were being judged to do the judging.<sup>4</sup> Such

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<sup>1</sup> As noted above, for the purposes of this thesis I will refer broadly to „The United Kingdom“ but this is limited to England and Wales and excludes specific analysis of Scotland, where the law is different.

<sup>2</sup> In particular, see Lord Scarman in *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1984] QB 493.

<sup>3</sup> *Bolam v Friern Hospital Management Committee (Bolam)* [1957] 1 WLR 582 and *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1984] QB 493.

<sup>4</sup> See for example *Rogers v Whitaker* (1992) 175 CLR 479, 489 „one consequence of the application of the Bolam principle ... medical opinion determines whether the risk should or should not be disclosed (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ) and *Reibl v Hughes* [1980] 2 SCR 880, 894 „this is to hand over to the profession the entire question of scope of duty of care.“

an approach does not accord with general negligence principles<sup>5</sup> and it perhaps represents a move away from the intent of the original judgment of *Bolam*. More recent decisions reflect an awareness of this underlying problem and there is a growing recognition of the role of the patient in the treatment conversation. This represents a shift to the middle ground in which the rights and duties of both the doctor and the patient are considered. We will explore the evolution of the standard test below but it is worth noting that the shift back to the patient is reflected in the most recent General Medical Council Guidelines on Consent. The Guidelines specifically focus on the partnership between the doctor and patient and clearly guide the doctor away from paternalistic practice towards a joint decision-making process.<sup>6</sup> This suggestion that there has been a shift in focus has recently been advanced by Miola.<sup>7</sup> He reasons that the '*Bolam* test' has become similar in effect to the traditionally more patient-oriented tests, especially in Australia<sup>8</sup> and goes so far as to question whether perhaps *Bolam* actually enhances autonomy.<sup>9</sup> We will explore this possibility in the following discussion which begins with a careful analysis of the actual decision of *Bolam*. We will then consider subsequent interpretations and applications of the decision.<sup>10</sup>

## The foundations of informed consent

[3.20] As discussed above, the test for informed consent in the United Kingdom is said to rest on interpretations of *Bolam*. The approach that has

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<sup>5</sup> J. Montgomery, *Health Care Law* (Oxford University Press, Oxford, 1997), 170 suggests that „this comes close to being a rule that doctors themselves set the standard of care required of them and that all that negligence does is to reinforce existing professional standards ... Such a rule would run against the normal principles of negligence, which require the judiciary to scrutinize standard practice to see whether it is reasonable.“

<sup>6</sup> General Medical Council, *Consent: patients and doctors making decisions together (Guidance for doctors)*, <<http://www.gmc-uk.org/guidance/125.asp>>at 20 January 2011. These Guidelines and the more recent decisions will be discussed in more detail below.

<sup>7</sup> Miola, J., „On the Materiality of Risk: Paper Tigers and Panaceas,“ (2009) 17 *Medical Law Review* 76.

<sup>8</sup> *Rogers v Whitaker* (1992) 175 CLR 479 represents the „panacea“ of his title.

<sup>9</sup> Miola, above n.7, 105.

<sup>10</sup> This will entail a consideration of *Bolam* followed by *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1985] AC 871 (Court of Appeal) *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1984] QB 493 (House of Lords). These three decisions provide insight into the evolution of the current position in the United Kingdom. Subsequent judicial and scholarly interpretations will also be explored.



emerged has been described as the ‘infamous *Bolam* test’<sup>11</sup> and subsequent key decisions appeal directly to the *Bolam* standard.<sup>12</sup> In Australia, *Rogers v Whitaker*<sup>13</sup> directly refers to (and rejects) *Bolam*.<sup>14</sup> Any discussion of ‘informed consent’ in the United Kingdom must therefore begin with the foundational decision of *Bolam*. The plaintiff in this instance was a voluntary patient suffering from depression. He was treated by electro-convulsive therapy (ECT) and suffered injury as a result of the manner in which the treatment was administered (he was neither given relaxant drugs nor restrained). The claim, for the purposes of this discussion, was that the doctor was negligent in failing to provide adequate warning of the inherent risks of the treatment<sup>15</sup> and there was some disagreement as to whether or not warning should have been given. It was ultimately concluded that in these circumstances, no warning was required.

The need to balance competing interests was clearly recognised by McNair J in his directions to the jury that began by highlighting the rarity of the injury and the enormous benefits conferred by this form of treatment.<sup>16</sup> This pattern of placing emphasis on the social utility of treatment is one that has been repeated in subsequent cases; policy is clearly a relevant factor underlying all discussions in the context of medical decision making, but it is not until 2005 that policy openly plays a central role.<sup>17</sup> In *Bolam* it was a relevant consideration but not yet a driving force.

In his measured judgment, McNair J took care to separate the emotive issues from the underlying legal question that he clearly limited to one of

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<sup>11</sup> Ibid, 78.

<sup>12</sup> See for example *Chatterton v Gerson* [1981] QB 432 which appeals directly to the *Bolam* standard, *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1984] QB 493 which begins from *Bolam* and moves forward and *Chester v Afshar* [2005] 1 AC 134 in which the *Bolam* standard is applied (these are only a handful of examples but are authoritative statements of the significance of the test).

<sup>13</sup> (1992) 175 CLR 479.

<sup>14</sup> See discussion above, n.4.

<sup>15</sup> There was also some debate regarding the actual treatment with respect to the use of relaxant drugs and restraints but these turned on questions of negligent treatment and are therefore not relevant in this context.

<sup>16</sup> *Bolam v Friern Hospital Management Committee (Bolam)* [1957] 1 WLR 582, 585-6 (McNair J).

<sup>17</sup> By the House of Lords in *Chester v Afshar* [2005] 1 AC 134, to be discussed below in the context of causation, and further explored in Part II, Chapter 6 (see [6.70]-[6.90]).

professional skill. He provided the jury with a definition of negligence as the failure to act in accordance with reasonable behaviour and asked it to determine what a 'reasonable man' would do in the circumstances.<sup>18</sup> The issue then became one of determining what is reasonable – the man on the Clapham omnibus was rejected as lacking the requisite medical skills. Also of note was the reminder to the jury that a 'skilled man' is not one who possess the highest expert skill, but simply 'an ordinary competent man exercising his art.'<sup>19</sup>

We now come to the fundamental question: How to determine the expected standard of skill? McNair J emphasised that a medical practitioner will not be negligent if he has acted 'in accordance with a practice accepted as proper by a *responsible* body of medical men skilled in that particular art.'<sup>20</sup> The second limb of the test was that the existence of a body of opinion with a 'contrary view' would not mean that his actions were negligent. The caution to the jury was that it was not essential for it to determine which of the two practices presented was the better practice, so long as they accepted that what the defendants did was in accordance with a practice accepted by responsible persons.<sup>21</sup>

The final points of the judgment recognise the difficulty of making treatment decisions when the doctor is dealing with a patient who is 'mentally sick.' In acknowledging that a doctor in this situation may be confronted with a difficult choice, McNair J expressed his view that a doctor 'cannot be criticised' for failing to emphasise risks which 'he believes to be minimal' in the treatment if he believes that the treatment is in the best interests of the patient who, by implication (because of the nature of his illness) could not

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<sup>18</sup> *Bolam v Friern Hospital Management Committee (Bolam)* [1957] 1 WLR 582, 586 (McNair J).

<sup>19</sup> *Ibid.*

<sup>20</sup> *Ibid.*, 587 (emphasis added). It is interesting to note that Miola has suggested that the term „responsible“ was forgotten by the Courts between 1957 and 1997, with the result being that Judges were not permitted to choose between expert witnesses resulting in an „absurdly low level of justification for their actions ... expected of doctors.“ Miola, above n.7, 79.

<sup>21</sup> *Ibid.*, 588.

comprehend or emotionally cope with such information.<sup>22</sup> This reads as a clear sanction of medical paternalism and, to a certain extent, undermines the otherwise balanced judgment directing the application of an objective test.

A straightforward reading of this decision indicates that:

1. policy is a relevant consideration,
2. the issue is one of professional standard,
3. professional standard is to be determined against a responsible body of peers, and
4. a level of medical paternalism is sanctioned when it may be viewed as detrimental to the patient's health to tell them of 'minimal risks.'<sup>23</sup>

The *Bolam* decision was subsequently endorsed in *Chatterton*<sup>24</sup> and further elaborated on in *Sidaway*.<sup>25</sup> It was in this latter case that the technicalities of informed consent and the *Bolam* case were closely analysed and *Bolam* is rarely, if ever, discussed without reference to *Sidaway*. It is therefore prudent to consider *Sidaway* before proceeding with any critique of the position in the United Kingdom.

### *Developing the Bolam test: Sidaway*<sup>26</sup>

[3.30] Discussion here will involve an analysis of each of the judges' reasoning in both the Court of Appeal and the House of Lords. This is an important analysis as it reveals the complexities of adjudicating pre-treatment advice (and the absence of a coherent or clear legal test). It has been said of *Sidaway*

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<sup>22</sup> Ibid, 590.

<sup>23</sup> This final point can be viewed as an early acceptance of therapeutic privilege.

<sup>24</sup> *Chatterton v Gerson* [1981] QB 432.

<sup>25</sup> *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1985] AC 871.

<sup>26</sup> Both the Court of Appeal (*Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1984] QB 493) and House of Lords (*Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1985] AC 871) decisions will be discussed here as both sets of judgments contain some illuminating discussions which clearly demonstrate the perception and evolution of the *Bolam* test.

that it contains a 'confusing mix of speeches,'<sup>27</sup> that it 'is impossible to find a majority view [as there] is little common ground to distil a consensus,'<sup>28</sup> and that 'the judgments throw up several different and irreconcilable approaches [making it] impossible to assign a *ratio decidendi* to the case.'<sup>29</sup> We will therefore explore the judgments in some detail with the aim of identifying any central principles and, of course, illustrating the key point that the language of consent diverts judicial attention from the true issues. If the focus were on the process of choice then it would be easier to identify, and state, a coherent principle as the Courts would be able to point to both the right that is being protected and the process that is potentially harmed by the provision of incomplete information.

### **The facts**

[3.40] Mrs Sidaway suffered from recurrent pain in her neck, right shoulder and arms and had been treated by a senior neurosurgeon for a number of years. It was finally decided that the best course of action was surgery and the procedure was carried out with all due care. The surgery carried an inherent and 'material risk' (put at somewhere between one and two percent) of damage to the spinal column and nerve roots. When the risk materialised and she experienced significant disability, Mrs Sidaway claimed that she was not informed of the risk. She sought damages for negligence relying on the failure of the surgeon to inform her of the risk.

### **Judgment: Court of Appeal**

[3.50] The discussion in the Court of Appeal provides some insight into the considerations underlying the professional standard test. Lord Donaldson reviewed the existing law across the United States and Canada, beginning

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<sup>27</sup> D.Meyers, „*Chester v Afshar: Sayonara, Sub Silentio, Sidaway?*“ in Sheila A.M. McLean , ed *First Do No Harm* (Ashgate, Aldershot, 2006), 259.

<sup>28</sup> Montgomery, above n.5, 244.

<sup>29</sup> Miola, above n.7, 83.

with the acknowledgment of the common position that to provide treatment in the absence of consent constitutes an assault. Despite this initial recognition of a potential trespass action, he took care to emphasise that it is not a matter of English law that a failure to give sufficient information will vitiate consent.<sup>30</sup> Trespass and quality of consent were therefore not relevant in this context; the issue was clearly one of negligence and professional standards. Thus despite labelling the issue as one of consent, His Lordship carefully stepped back from traditional consent issues. He took care to place the discussion within the negligence framework and focus not on the needs of the patient but on the duties of the doctor.

Lord Donaldson went on to emphasise the significance of the position of trust held by the doctor and asserted that the law will not 'permit the medical profession to play God.'<sup>31</sup> These statements were tempered by his view that the 'prudent patient is a rare bird'<sup>32</sup> and that the doctor knows (or ought to know) the patient's true wishes, which may or may not coincide with what the patient is actually saying.<sup>33</sup> This observation elevated the medical practitioner to a position in which he or she is able to lead the patient towards a 'rational' decision. In his judgment, Lord Donaldson added a significant caveat to the *Bolam* test: the actions of a professional must be in accordance with a practice *rightly* accepted as proper by a body of skilled and experienced men.<sup>34</sup> He therefore left us with an interesting and partially contradictory test that appears to rely upon a 'right' and all-knowing doctor who is able to guide the patient to rational decisions. This then leaves open the question as to who is to determine what is rational? This is an exceptionally difficult question to answer, especially if one accepts that the patient is unlikely to be prudent and possibly incapable of expressing (or even knowing) their true wishes. The necessary implication is that the

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<sup>30</sup> *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1984] QB 493, 511 (Lord Donaldson).

<sup>31</sup> *Ibid*, 513.

<sup>32</sup> *Ibid*.

<sup>33</sup> *Ibid*, 513-514.

<sup>34</sup> *Ibid*, 514.

determination of what is rational rests with the doctor who provides sufficient information to guide the patient towards the most appropriate decision (as defined by the doctor).

Lord Dunn also took time to clearly reject the 'transatlantic doctrine' of informed consent and to emphasise that if there is consent to the nature of the act, then there is no trespass to the person.<sup>35</sup> His judgment began with a promising recognition of patient interests and needs when he noted that doctors treat patients and not diseases.<sup>36</sup> But he managed to resile from this position by emphasising that the decision to provide warnings (or not) is a question of clinical judgment and therefore of professional standard. Significantly, he further asserted that the majority of patients prefer to rely unreservedly on the doctor and that to view it any other way would be detrimental to medical care leading to an increase in claims and the practice of defensive medical care.<sup>37</sup>

Lord Browne-Wilkinson also placed emphasis on the social utility of the doctor/patient relationship and asserted that the duty of care imposed on the medical profession needs to be realistic and not detract from the proper function of caring for the sick. To introduce a more stringent (or perhaps patient-centred) test would, in his view, expose doctors to the threat of legal proceedings with actions being judged by hindsight and not by the standard of 'those skilled in the art but by judges or juries.'<sup>38</sup>

The Court of Appeal decision recognised the significance of the patient in the decision-making process, but gave greater weight to policy considerations. Relevant considerations included the social utility of the provision of medical care without fear of litigation. The doctrine of informed consent, in the view

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<sup>35</sup> *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1984] QB 493, 516 (Dunn LJ).

<sup>36</sup> *Ibid.*

<sup>37</sup> *Ibid.*, 517.

<sup>38</sup> *Ibid.*, 523 (Browne-Wilkinson LJ).

of the Court of Appeal, clearly represented a threat to the provision of medical care in general and the doctor/patient relationship in particular. The *Bolam* test was endorsed as the appropriate test, with the medical practitioner being elevated to a powerful position of knowledge and, one could infer, insight and wisdom above that of their patients. But without a consistent approach, the decision left open some important questions which is perhaps why it went on to appeal in the House of Lords.

### **Judgment: House of Lords**

[3.60] Lord Scarman's dissenting judgment in the House of Lords is the closest that any Law Lord has come to the Australian<sup>39</sup> and American positions. Indeed, it is his judgment that is often viewed as the most persuasive.<sup>40</sup> His Lordship acknowledged that he was attracted by the American acceptance of informed consent and argued that there was a need to look beyond the *Bolam* test. His summation of this test was that the law imposed a duty of care with the standard of care being a matter of medical judgment. This is a situation which he viewed as 'disturbing' as it left the determination of a legal duty to the judgment of doctors.<sup>41</sup>

Lord Scarman did not deny the relevance of medical evidence. He recognised that medical opinion might provide the law with an acceptable standard in determining whether a doctor, in diagnosis or treatment, has complied with his duty. At the same time, however, he questioned whether it is right that medical judgment should determine the existence of a duty to warn of risk and its scope.<sup>42</sup> Indeed, he described it as a 'strange conclusion' that the Courts accept that the law recognises a right in the patient to decide whether

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<sup>39</sup> To be discussed in Chapter 4, also see Miola, above n.7, 81.

<sup>40</sup> Despite his clear rejection of *Bolam* and the fact that he was the only dissenting Judge, his comments are often referred to and some go so far as to suggest it has been adopted by later judgments. See for example Meyers claim that *Pearce v United Bristol Healthcare NHS Trust* [1999] ECC 167 „essentially adopted Lord Scarman“s minority speech in *Sidaway*“, Meyers, above n.27, 259.

<sup>41</sup> *Sidaway v Board of Governors of the Bethlehem Royal Hospital & Maudsley Hospital & Ors* [1985] AC 871, 881-2 (Lord Scarman).

<sup>42</sup> *Ibid*, 882.

to undergo treatment, yet permits doctors to determine whether and in what circumstances a duty arises in the context of warning prior to making that decision.<sup>43</sup> The most significant conclusion is his strong statement that the Court should not allow the profession to judge its own cause and therefore give rise to a situation in which the medical view of what is best for the patient overrides that patient's right to decide for themselves whether they will submit to the treatment.<sup>44</sup> In Lord Scarman's view, the patient should be at the centre of the test for standard of care, not the doctor.

An interesting inclusion in this judgment is recognition of factors beyond the purely medical.<sup>45</sup> Lord Scarman took care to note that there are many factors influencing a patient's decision-making process. In his view, it is important that doctors recognise that whilst their concern is with health and the relief of pain, the patient may well 'have in mind circumstances, objectives and values which he may reasonably not make known to the doctor.'<sup>46</sup> In short, the doctor's duty arises from the patient's rights.<sup>47</sup>

Lord Scarman's endeavours to return the patient to centre stage were, however, in vain with the rest of the Law Lords embracing the *Bolam* test and viewing the question from the opposite end of the relationship. It was their position that the question centres around the doctor's duty as viewed by other doctors with the patient's rights receiving at best, collateral benefit.

The judgment of Lord Diplock provides a contrast to that of Lord Scarman and is viewed as the most conservative of the judgments.<sup>48</sup> He also began

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<sup>43</sup> Ibid.

<sup>44</sup> Ibid.

<sup>45</sup> This recognition is important in the context of defining autonomy. As will be seen in Part III, Chapter 10 at the heart of the autonomy debate sits a clear divide between individualistic and relational models of autonomy with the latter, similarly to Lord Scarman, emphasising the significance of the impact of external factors on the individual.

<sup>46</sup> *Sidaway v Board of Governors of the Bethlehem Royal Hospital & Maudsley Hospital & Ors* [1985] AC 871, 885-6.

<sup>47</sup> Ibid, 886.

<sup>48</sup> Miola, above n.7, 81 and 82, and Kenyon Mason & Douglas Brodie, „*Bolam, Bolam* - Wherefore Art Thou *Bolam*?" (2005) 9 *Edinburgh Law Review* 298, 300.



from the position of the patient, noting that the doctor's duty of care is owed to the particular patient before them, 'idiosyncrasies and all.'<sup>49</sup> Despite starting with the patient, he quickly moved to a clearly doctor-centric test. The individual patient's idiosyncrasies serve to guide the doctor in the exercise of his professional skill and judgment about whether it is in the patient's best interest to take the risk and undergo the recommended treatment.<sup>50</sup> In other words, according to Lord Diplock, it is left to the doctor to determine what is in the patient's best interests and then proceed on the basis of this determination. The role of the doctor is to heal the patient and if this means proceeding with a risky procedure, then the doctor is best qualified to determine that such treatment is appropriate. The patient's views, unless expressly stated through direct questioning, were of little interest to Lord Diplock. Thus we have a clear identification of a personal right which is to be measured and protected by scrutinising the content of another's professional duty. This concern was also raised in Chapter 2 when we were considering the relevant test in the United States. As was explained there, this approach is inconsistent with Hohfeld's 'jural correlatives' and means the significance of the patients' perspective is diminished.<sup>51</sup>

Lord Diplock also appealed to broad, public policy questions, focussing on the public interest in the advancement of medicine over the individual, perhaps idiosyncratic, needs of the patient. His Lordship viewed it as appropriate to focus on accepted medical practice as opposed to the individual patient. To his mind the body of opinion in support of the level of information given by the neurosurgeon was determinative.<sup>52</sup> Of significance was his view that to broaden the duty and focus more on the individual patient would result in the practise of defensive medicine with doctors only

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<sup>49</sup> *Sidaway v Board of Governors of the Bethlehem Royal Hospital & Maudsley Hospital & Ors* [1985] AC 871,891, (Lord Diplock).

<sup>50</sup> *Ibid.*

<sup>51</sup> See discussion above, Chapter 2: The scholarly view of Canterbury (at [2.60]), and text accompanying fn 92.

<sup>52</sup> *Ibid.*, 892.

providing 'tried and true' methods as opposed to being prepared to 'stretch the outer parameters.'<sup>53</sup>

Lords Scarman and Diplock are the two extremes of the judgments and, as suggested by Miola, the remaining Judges represent the middle way.<sup>54</sup> Whilst it has been suggested that Lord Templeman's speech is 'the most significant' of all<sup>55</sup> it has also been described as 'unclear.'<sup>56</sup> Thus it is fair to say that the judgments are open to interpretation. I suggest that Lords Bridge and Templeman aim to balance the competing interests and, similarly to Miola, I argue that their speeches represent an attempt to walk the middle ground between doctor and patient. Lord Bridge (with Lord Keith concurring) began with an emphasis on the right of a competent patient to determine whether or not to proceed with treatment.<sup>57</sup> This significant right, as explained by Lord Bridge, is subject to practical realities. This reference to 'realities' signalled yet another retreat into policy considerations. Lord Bridge focussed on the practical difficulties of determining the appropriate standard based upon the needs of the patient. In his view, a decision regarding the degree of disclosure so as to enable a patient to make a 'rational choice' must primarily be a matter of clinical judgment.<sup>58</sup> The all-knowing medical practitioner recognised in the Court of Appeal was once again returned to a central position. His Lordship did, however, stop short of creating a completely bullet-proof doctor and recognised that there may be 'rare situations' in which a judge may intervene if he or she concludes that disclosure was so 'obviously necessary' that no 'prudent medical man' would fail to warn.<sup>59</sup> Unfortunately he failed to provide any guidance as to how such a determination should be made.

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<sup>53</sup> Ibid, 893.

<sup>54</sup> Miola, above n.7, 83.

<sup>55</sup> Mason and Brodie, above n.48, 300.

<sup>56</sup> M.A. Jones, *Medical Negligence*, (3<sup>rd</sup> ed, Sweet and Maxwell, London, 2003), [6-113].

<sup>57</sup> *Sidaway v Board of Governors of the Bethlehem Royal Hospital & Maudsley Hospital & Ors* [1985] AC 871, 897 (Lord Bridge).

<sup>58</sup> Ibid, 900.

<sup>59</sup> Ibid.

The final judgment is that of Lord Templeman who came to the conclusion that the procedure was so obviously risky that Mrs Sidaway should have been alert to the possibility of something going wrong near the site of the nerve root. In his view, any additional warning could only have 'reinforced that possibility.'<sup>60</sup> He then proceeded to cast doubt upon Mrs Sidaway's ability to comprehend and in an apparent contradiction to this statement, he emphasised that she could have asked questions. Alternatively, he suggested that it is possible that the surgeon could have reasonably taken the view that she would have been confused, frightened or misled by more information.<sup>61</sup> He concluded with the view that the doctor must exercise his professional judgment and determine what is the appropriate level of information.

Consistent with the Court of Appeal, the House of Lord's judgments were clearly driven by policy considerations. The significance of medical advancement and recognition of the professional status of the doctor combine to create a test dictated by professional standards. The *Bolam* test thus evolved into a clearly doctor-centric one with the views of the individual patient relegated to the sidelines. Despite recognition of the significance of the patient's right to determine what is to be done to their body, the views of the individual patient do not appear to be a consideration in applying the professional standard approach. At this point in the development of the law in the UK it would appear that 'informed consent' has little to do with the views of the patient and is entirely determined by the exercise of the medical practitioner's skill and judgment. Furthermore, whether the duty has been met is to be determined by evidence from other medical practitioners, with the Court being relegated to the role of facilitator as opposed to decision maker.

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<sup>60</sup> Ibid, 902 (Lord Templeman).

<sup>61</sup> Ibid.

It is important to pause here and explain my approach to the role of policy in judicial decision-making. It is not my aim to challenge the validity of policy considerations or question their adoption by the Courts. My main concern is the ease with which reference is made to policy when it is unclear what or whose policy is being applied. As we are still considering the actual judgments and identifying references to such issues as the role of policy, the questions as to what or whose policy is being applied will be put to one side for the moment. It is sufficient here to recognise the role of policy in judicial decision-making and it will be discussed in detail in Chapter 9.<sup>62</sup>

### **Interpretations of Bolam and Sidaway**

[3.70] The basic proposition of the *Bolam* test as elaborated in *Sidaway* is a fairly straightforward one. The doctor clearly owes the patient a duty of care which includes a responsibility to disclose some risks prior to treatment. The standard of care is to be determined by reference to accepted practice but the Courts will not allow the medical profession to ‘play God.’ Despite this apparent clarity, the position of the Courts has developed into one of ready acceptance of professional opinion and a clear reluctance to question such evidence.<sup>63</sup> Indeed, it has been suggested that the *Bolam* test has been so broadly applied that it has been allowed to become a test not just of medical practice but also of medical ethics with informed consent being ‘hustled into a *Bolam* straightjacket.’<sup>64</sup> It could be argued that *Bolam* has dominated so effectively that the test focuses entirely on the doctor to the exclusion of the patient. This would, however, represent an overly simplistic view and overlook some significant judicial and scholarly discussions of the *Bolam* principle. It is to these discussions that we will now turn.

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<sup>62</sup> Refer below, Chapter 9 ‘Causation and policy’ (at [9.10]).

<sup>63</sup> In *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635, 638 and 639 Lord Scarman clearly stated that it is not up to the Court to choose between differing professional opinions. His Lordship noted that, ‘there is seldom only one answer exclusive of all others ... A Court may prefer one body of opinion to the other but it is no basis for a conclusion of negligence.’ This is a position which Miola, above n.7, 79 suggests made it ‘almost impossible for plaintiffs to win cases.’

<sup>64</sup> M.Brazier and J.Miola, ‘Bye Bye Bolam: A Medical Litigation Revolution?’ [2000] 8 *Medical Law Review* 85, 90.

### *The Courts: Putting a gloss on the professional standard test*

[3.80] *Bolam* has consistently been acknowledged as the appropriate test in the context of the provision of pre-treatment advice.<sup>65</sup> A standard approach of the Courts has been to reject first the notion of trespass and then that of informed consent. The central theme of professional standard is always clearly established but once the test is discussed some subtle but significant departures from the original formulation become apparent. The result is that through the progression of time, and wide application, the test has had a gloss placed on it which perhaps moves it away from its initial intention.

*Chatterton v Gerson*<sup>66</sup> explained the *Bolam* test as being a duty of the doctor to explain the treatment and its implications in the way a 'careful and responsible' doctor would do,<sup>67</sup> whilst the judgment in *Hills v Potter* introduced the additional notion of the respectable and responsible doctor.<sup>68</sup> The question then becomes: How does one determine what is 'responsible', 'careful' and 'respectable' – and who is to determine it? A hint of a solution was expressed by Lord Browne-Wilkinson in *Bolitho v City Hackney Health Authority (Bolitho)* when he suggested that the use of these adjectives means that the Court must be satisfied that the professional practice has a logical basis.<sup>69</sup> Unfortunately he failed to indicate how the Court is to be satisfied of this outside of the professional evidence before it. On another reading, the use of these adjectives to classify the type of doctor who gives acceptable advice, reflects the Courts' discomfort with simple acceptance of professional

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<sup>65</sup> See for example: *Bolitho v City and Hackney Health Authority Respondents* [1998] AC 232, 239ff, *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634, 638 (Lord Scarman), *Chatterton v Gerson* [1981] QB 432, 443 (Bristow J), *Chester v Afshar* [2005] 1 AC 134, [52] ff (Judge Robert Taylor), *Hills v Potter* [1984] 1 WLR 641, 645 (Hirst J), *Pearce v United Bristol Healthcare NHS Trust* [1999] PIQR 53, 58 and in *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1985] AC 871, 884 Lord Scarman refers us to the „formidable English authority accepting the *Bolam* test“ (this is clearly a non-exhaustive list. Any decision referring to pre-treatment advice will refer to *Bolam*).

<sup>66</sup> [1981] QB 432. This was a case involving the development of chronic and unendurable pain around a scar following a hernia operation and subsequent treatment to block the sensory nerve.

<sup>67</sup> *Ibid*, 443 (Bristow J).

<sup>68</sup> [1984] 1 WLR 641,653 (Hirst J).

<sup>69</sup> [1998] AC 232, 242 (Lord Browne-Wilkinson).

evidence, along with their inability to create a test which challenges professional evidence with any rigour. The judiciary was at an impasse: on the one hand there was recognition that it is inappropriate to allow the medical profession to judge itself; on the other hand, there was the recognition that the Courts are ill equipped to evaluate the exercise of clinical skills.

The solution to this problem was provided in *Bolam* and *Sidaway* when the conclusion turned on basic policy considerations. Although as noted above, this is problematic because the nature of the relevant 'policy' is not made clear. Perhaps in response to this uncertainty subsequent judicial interpretations of these decisions have resiled from this aspect of the decisions and have declined to openly acknowledge the significance of policy considerations. The interpretation of the *Bolam* test has generally been couched in strict legal terms: what would the prudent professional have done? It is only when one closely considers some of the earlier decisions and looks beyond the legal eloquence that the role of policy becomes apparent. Unfortunately it is not always policy grounded in patient interests; more often it is policy aimed at protecting the medical profession.<sup>70</sup>

Between *Bolam* and *Sidaway* was the decision of *Chatterton v Gerson*<sup>71</sup> which saw a straightforward application of the *Bolam* test. Bristow J recognised the imperative to warn the patient,<sup>72</sup> but his imperative was clearly tempered by other considerations. As noted above, he appealed to the standard of a careful and responsible doctor,<sup>73</sup> but placed his determination in the context of a stated 'fundamental' assumption that the doctor knows his job and will

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<sup>70</sup> This position has evolved over recent years and at the causation stage we are now seeing an increased emphasis placed upon normative questions of what *ought* the doctor have done. This shift is clearly demonstrated by the decision in *Chester v Afshar* [2005] 1 AC 134 and we will discuss the significance of this when the role of causation is analysed in Part II and the role of policy more closely considered in Chapter 9.

<sup>71</sup> [1981] QB 432.

<sup>72</sup> *Ibid*, 436.

<sup>73</sup> *Ibid*, 443.

do it properly.<sup>74</sup> Such a strong assumption is difficult to displace and reflects a true reluctance to challenge the professional opinion of the treating doctor. Bristow J took care to recognise the relevance of the personality of the patient and their welfare but considered this in the light of the doctor's view of these issues.<sup>75</sup> The practical result is that if the doctor believes that withholding information and proceeding with treatment is in the patient's best interest, then their actions are unlikely to be questioned by the Court. The consideration of what is appropriate is therefore from the perspective of the medical profession and not the patient.

A few years after this came the decision of *Hills v Potter*<sup>76</sup> in which the outcome of the medical treatment was unreservedly described as a complete and total tragedy.<sup>77</sup> The plaintiff underwent a procedure aimed at alleviating (but not curing) a deformation of the neck and as a result suffered paralysis from the neck down. On the evidence, prior to the time of the operation there were no recorded cases of paralysis and the treatment itself was never viewed as a complete cure. The best outcome involved a 70-80% improvement.<sup>78</sup>

The evidence as presented by the defendant was that he would always explain the operation with some variation in advice, dependent upon the particular patient's ability to understand. He emphasised that he would never exaggerate the risks and agreed that he would have made some reassuring statements in order to calm the patient as in his view, she was 'overestimating the dangers.'<sup>79</sup> This evidence (and the subsequent acceptance of it) emphasises the significance of the view of the professional as opposed to that of the patient. If a patient is concerned about a specific risk (she asked questions about paralysis) and these risks are down-played by the doctor, and in reliance on this she proceeds with the treatment and suffers the very risks

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<sup>74</sup> Ibid, 444.

<sup>75</sup> Ibid.

<sup>76</sup> [1984] 1 WLR 641.

<sup>77</sup> Ibid, 643 (Hirst J).

<sup>78</sup> Ibid, 645.

<sup>79</sup> Ibid.

she was concerned about, how can one honestly conclude that she was overestimating the very danger that materialised?

Hirst J accepted the professional evidence that the warning (or lack of warning) was in accordance with professional standards and therefore found that the requisite standard was met. Of interest is the fact that he acknowledged the concern that the *Bolam* test involves an 'abdication' of the Court's powers but clearly rejected such a proposition. His position was that the Court must be satisfied that a respectable and responsible body of opinion accepts the standard,<sup>80</sup> yet he failed to provide any guidance on how the Court is to be so satisfied. Once again we see that the inherent respect for the evidence of medical professionals appears to drive the decisions and there is an absence of any clear indication of how professional evidence is to be challenged. This decision is consistent with the judicial approach of not really challenging medical professional standards.

The Courts continued to apply the *Bolam* test without any significant variation until the 1998 decision of *Bolitho*<sup>81</sup> which Lord Woolf, writing extra-judicially, describes as explaining the *Bolam* test in a manner less deferential to the medical profession,<sup>82</sup> Brazier and Miola suggest that it returned the *Bolam* test to its proper limits<sup>83</sup> whilst Jackson describes *Bolitho* as representing a more robust version of the *Bolam* test and posits that the 'excessively deferential interpretation must now be in doubt.'<sup>84</sup> This scholarly commentary must, however, be put into the appropriate context: the *Bolitho* decision specifically dealt with diagnosis and treatment with a central question of causation. It was not at all concerned with the provision of pre-treatment advice. Thus to attempt to give it a broad application and proclaim it as removing the

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<sup>80</sup> Ibid, 647.

<sup>81</sup> *Bolitho v City and Hackney Health Authority* [1998] AC 232.

<sup>82</sup> Lord Woolf, „Are the Courts Excessively Deferential to the Medical Profession,“ (2001) 9 *Medical Law Review* 1, 10.

<sup>83</sup> Margaret Brazier and Jose Miola, above n.64, 87.

<sup>84</sup> E. Jackson, *Medical Law: Text, Cases and Materials* (Oxford University Press, Oxford, 2006), 125.



'straight-jacket'<sup>85</sup> of *Bolam* is an over-simplification and risks giving *Bolitho* a breadth of application that is not appropriate.

The fact scenario involved the death of a child. There was some dispute over the facts but they were settled at trial. The child was in hospital and suffered two episodes of serious (and ultimately fatal) respiratory distress. On both occasions there were calls by the nurses for doctors to attend. The doctors failed to respond to these calls and this was accepted as negligent. The issue was whether or not this made any difference to the ultimate outcome which was respiratory distress leading to cardiac arrest and 'catastrophic' brain damage. The respondents' position was that even if the doctors had attended when paged they would not have intubated the child, which was the only course of treatment that would have averted the tragedy. The hospital successfully argued that the negligence of the doctors did not cause the damage suffered. Thus in the face of clear negligence, the plaintiff stumbled at the causation stage of the enquiry.<sup>86</sup>

In his judgment Lord Browne-Wilkinson endeavoured to clarify the issues by drawing a line between the questions of what would have occurred as opposed to what should have occurred. In the process of drawing this line he raised the question of who should give evidence for both the 'would' and 'should' questions.<sup>87</sup> His conclusion was that the doctor informs the Court of what they would have done and it is the evidence of the medical fraternity that goes to the 'should' question which then assists the Court to make a decision.<sup>88</sup> He then reasserted the authority of the Court and referred to the adoption of adjectives such as 'responsible', 'reasonable' and 'respectable' in the context of acceptable medical behaviour.<sup>89</sup> Of significance in this decision is his additional requirement of a 'logical basis' and the need for the Court to

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<sup>85</sup> This description of *Bolam* was made in M.Brazier and J.Miola, „Bye Bye Bolam: A Medical Litigation Revolution?“ [2000] 8 *Medical Law Review* 85, 90.

<sup>86</sup> The problematic nature of causation in medical negligence will be explored in some detail in Part II.

<sup>87</sup> *Bolitho v City and Hackney Health Authority* [1998] AC 232, 237.

<sup>88</sup> *Ibid*, 238.

<sup>89</sup> *Ibid*, 241.

be satisfied that the medical opinion has such a basis.<sup>90</sup> It is this addition to the *Bolam* test which has been viewed as significant, resulting in the Courts reclaiming a key role in the decision making process.

Thus despite scholarly assertions regarding the impact of *Bolitho* on the *Bolam/Sidaway* test, the impact of the decision on the standard of disclosure can, however, only be described as minimal. Not only did His Lordship describe the assessment of medical risks and benefits as matters of clinical judgment with which the Court is unlikely to interfere, but he also explicitly stated that he was not considering questions of disclosure of risks.<sup>91</sup> Two clear points can thus be made. Firstly, this decision does not bring any real clarity to the debate and secondly, careful consideration of the judgment reveals an ongoing deference to medical opinion with Lord Brown-Wilkinson referring to evidence from the treating doctor and the medical fraternity, not the individual patient. *Bolitho* is therefore of limited relevance to the current discussion and we need to turn to other decisions which specifically address the question of pre-treatment advice.

Shortly after *Bolitho* came the decision of *Pearce v United Bristol Healthcare NHS Trust*<sup>92</sup> which, it has been claimed, indicated that the judicial pendulum was swinging back in favour of patients.<sup>93</sup> This optimistic claim (made by the presiding judge, and some scholars) overlooks the outcome of the decision and the reality of the test applied which, despite appearing at first glance to be approaching the Australian position of material risk, is in fact centred on

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<sup>90</sup> Ibid. It is interesting to note that in Australia, under the „Civil Liability Acts’ the „*Bolam* test’ has been given legislative form for diagnosis and treatment (pre-treatment advice is specifically excluded). This addition of a „logical basis’ to the *Bolam* test is also given legislative recognition with the Courts given the freedom to reject peer professional opinion (regarding diagnosis and treatment) if the Court is of the view that it is „irrational’. *Civil Liability Act 2002* (NSW) s50, *Civil Liability Act 2003* (Qld) s22, *Civil Liability Act 1936* (SA) s41, *Civil Liability Act 2002* (Tas) s22, *Wrongs Act 1958* (Vic) s59 (this section refers to „unreasonable’ as opposed to „irrational”).

<sup>91</sup> Ibid, 243.

<sup>92</sup> [1999] ECC 167.

<sup>93</sup> Refer Lord Woolf, above n.82, see also Meyers, above n.27, 258ff. Jackson, above n.84, 276 and 277 also raises this issue.

professional opinion and judgment of what is 'significant' with individual patient perceptions being irrelevant.

The plaintiff was pregnant and 14 days overdue when she attended the hospital on the 27<sup>th</sup> November. She begged the doctor either to induce the child or perform a caesarean section. He advised against both of these procedures. There was some evidence that during this consultation the doctor told Ms Pearce not to 'behave like a child' and informed her that to induce was risky and that the caesarean was not his preferred option. She later delivered a stillborn infant on the 4<sup>th</sup> of December. The issue turned on whether she should have been informed of an increased risk to the child with further delay and whether she would have changed anything if she had been so informed.<sup>94</sup>

In his judgment, Lord Woolf acknowledged that if a plaintiff asks a doctor about a certain risk, then he is clearly bound to provide an 'honest answer.'<sup>95</sup> The discussion then focussed on what is appropriate in the absence of such a request. Lord Woolf canvassed the 'closely reasoned speech' of Lord Scarman in *Sidaway* but rejected it as not reflecting the law of 'this jurisdiction.'<sup>96</sup> He then adopted a position similar to that of *Bolitho*, arguing that whilst in the vast majority of cases if 'distinguished experts in the field' are of an opinion it will demonstrate reasonableness, it is still open to the Court to determine that the opinion is neither reasonable nor responsible if it can be demonstrated that it is not capable of withstanding logical analysis.<sup>97</sup>

This position holds some promise of a shift to a more patient-centred test, but Lord Woolf then clarified his view by noting that it will be 'very seldom right for a judge to reach a conclusion that views genuinely held by a competent

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<sup>94</sup> Ibid, 170, the second question of causation is addressed in Part II, Chapter 6.

<sup>95</sup> Ibid, 169.

<sup>96</sup> Ibid, 170-171.

<sup>97</sup> Ibid, 173-4.

medical expert are unreasonable,<sup>98</sup> a statement which contains echoes of the *Maynard* comments that it is 'not up to the Court to choose between differing professional opinions.'<sup>99</sup> Consistent with earlier judgments, the reason for this assertion was the clinical nature of the decision to discuss (or not) certain risks. We see then that individual patient needs are not relevant to disclosure (unless they have the wherewithal to ask specific and detailed questions). The issue is solved through consideration of clinically-defined factors, not individual needs.

The notable addition to the *Bolam* test was the concept of a 'significant' risk. Lord Woolf stated that if there is a significant risk which would affect the judgment of a reasonable patient, then the doctor must inform the patient of that risk.<sup>100</sup> It would appear that the Court here was endeavouring to provide a measure for the determination of reasonable and responsible treatment – and that perhaps this measure focuses on patient needs. But this is not the case. The definition of what constitutes significant did not rely upon patient characteristics or needs or desires. It was instead given a statistical value – in His Lordship's view, a risk will be significant if it has around a 10% chance of manifesting.<sup>101</sup>

Where does this leave the patient? Lord Woolf noted that a doctor must take into account all relevant considerations and these include the ability of the patient to understand along with their physical and emotional well being.<sup>102</sup> In this situation, the increased risk of stillbirth was estimated at somewhere between 0.1% and 0.2% and was therefore not deemed to be 'significant.' One cannot help but wonder what Ms Pearce would have said if asked whether

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<sup>98</sup> *Ibid.*, 174.

<sup>99</sup> *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635, 638 and 639, see comments above, n.63.

<sup>100</sup> *Pearce v United Bristol Healthcare NHS Trust* [1999] ECC 167, 174.

<sup>101</sup> *Ibid.* Jackson, above n.84, 277 makes a similar point when she notes that his Lordship „appeared to rely upon the *doctor's* judgment of whether the risk was significant, and not Tina Pearce's own assessment of whether the risk was sufficiently material that it would have affected her decision to accept medical advice and proceed with a natural birth.“

<sup>102</sup> *Pearce v United Bristol Healthcare NHS Trust* [1999] ECC 167, 174.

the loss of her child was a 'significant' risk? In Lord Woolf's view, if she had been informed of this 'particularly small risk' she probably would not have been able to understand the warning and would therefore have 'reluctantly' followed the advice of the doctor and waited.<sup>103</sup> This reflects a paternalistic view of the patient who, unable to understand the implications of medical advice, would quietly follow the guidance of the doctor. If the focus is truly on the patient and their individual right to information, perhaps a better question would have been, why would the doctor have been incapable of describing straightforward life-and-death issues in a manner suited to the needs of his patient?

Despite suggestions to the contrary it can therefore be seen that the general judicial interpretation of the *Bolam* test has entailed respect for the professional and clinical judgment of the medical profession, combined with a protective view of the patient. What constitutes a risk that must be disclosed to a patient is determined by factors entirely external to the patient and in the context of deference to medical professional opinion. The patient is not an active participant in the process and, it would appear, is not deemed capable of determining what is significant to them.

### *The scholarly view of Bolam and Sidaway*

[3.90] The *Bolam* test clearly plays a central role in the determination of medical negligence; it has been described as the 'touchstone'<sup>104</sup> and the 'benchmark test'<sup>105</sup> of a doctor's duty of care. Some view it as having the advantage of clarity, with a standard understood by both the medical and legal professions.<sup>106</sup> Others have described it as ambiguous<sup>107</sup> and as

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<sup>103</sup> Ibid, 175.

<sup>104</sup> M.A. Jones, above n.56, [3-208].

<sup>105</sup> Mason and Brodie, above n.48, 299.

<sup>106</sup> Ibid.

<sup>107</sup> M.A. Jones, above n.56, [3-106].

presenting a situation in which ethical requirements and legal tests diverge.<sup>108</sup> Any scholarly discussion of *Bolam* invariably includes consideration of *Sidaway*, and the commentary is not always complementary. Meyers refers to the ‘confusing mix of speeches in *Sidaway*’<sup>109</sup> and goes on to argue that after *Sidaway* ‘jurisprudence and doctors were left adrift ... [and there were] no meaningful criteria’<sup>110</sup> Jackson also remarks on the lack of clarity<sup>111</sup> whilst Montgomery and Miola argue that it is impossible to identify a ‘majority view [or] common ground to distil a consensus’<sup>112</sup> and that it is ‘impossible to assign a *ratio decidendi* to the case [because] the judgments throw up several different and irreconcilable approaches.’<sup>113</sup> It is therefore a test which has attracted much ongoing discussion and analysis with one consistent theme: a scholarly striving to comprehend the true nature of the test and a challenge to its appropriateness and relevance. Is it a test which turns on patient needs or professional practices?

Whilst the Courts have consistently emphasised that the test is not about the medical profession, with the judiciary remaining as the final arbiters of the law, this certainty is not echoed in the literature. A common interpretation of the *Bolam* test is that it is up to the medical profession to determine appropriate behaviour. It has been described as the test, ‘any responsible doctor knows best,’<sup>114</sup> and Brazier and Miola have suggested that all the test requires is that a medical professional find some other expert to declare that they would have acted in the same manner, reducing the Court to a form of ‘trial by battle’ in which each side pits their ‘champion expert’ against the other.<sup>115</sup> More recently, Miola, continuing his exploration of the *Bolam* test, has referred to the ‘absurdly low level of justification for their actions that was

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<sup>108</sup> I.Kennedy, „The Patient on the Clapham Omnibus“ (1984) 47 *Modern Law Review* 454, 457.

<sup>109</sup> Meyers, above n.27, 259.

<sup>110</sup> *Ibid*, 260.

<sup>111</sup> Jackson, above n.84, 269.

<sup>112</sup> Montgomery, above n.5, 244.

<sup>113</sup> Miola, above n.7, 83.

<sup>114</sup> Lord Woolf above n.82, 5.

<sup>115</sup> Brazier and Miola, above n.64, 86-89.

expected of doctors.<sup>116</sup> Absent from the test are two key players: the Court and most significantly, the patient. Patient autonomy does not even rate a mention.

The true weakness of the test as perceived by commentators is that it operates to protect the doctor as opposed to the patient.<sup>117</sup> The emphasis of the Courts has been on a general protective policy that focuses on the medical profession, the doctor-patient relationship and the standard of medical treatment.<sup>118</sup> Despite this apparent condemnation of the test, the commentary is not all negative. Whilst Miola raised the concerns (outlined above) about the basic *Bolam* test, he has opined that subsequent decisions have enabled the test to evolve into something more patient-friendly, even going so far as to suggest that *Bolam* perhaps enhances patient autonomy.<sup>119</sup> As highlighted in the preceding discussion, two decisions are seen by some scholars as representing a shift to a more patient-centred approach: *Bolitho*<sup>120</sup> and *Pearce*.<sup>121</sup> It has been suggested that both of these decisions have redressed the doctor/patient imbalance and introduced clarity to the test.<sup>122</sup> However, as argued above, I challenge this view as it ignores the fundamental flaws in the test and fails to recognise that in both of these decisions, the medical professional continues to occupy a position of strength and control with the patient, once again, relegated to the sidelines as an observer. Indeed in *Pearce* both the doctor and the Court reduce the patient to a level similar to that of a child, unable to understand or process basic information regarding an important aspect of

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<sup>116</sup> Miola, above n.7, 79.

<sup>117</sup> Kennedy, above n.108, 460 suggests that the test serves to protect the doctor whilst M.A. Jones, „Informed Consent and Other Fairy Stories“ (1999) 7 *Medical Law Review* 103, 107 when highlighting the weaknesses of the *Bolam* test points out that it can be viewed as a means of protecting doctors from litigation.

<sup>118</sup> For further discussion of this refer Kennedy, *ibid*, and Lord Woolf, above n.82 Both authors raise serious concerns about the central focus of the test.

<sup>119</sup> Miola, above n.7, 105.

<sup>120</sup> *Bolitho v City Hackney Health Authority (Bolitho)* [1998] AC 232.

<sup>121</sup> *Pearce v United Bristol Healthcare NHS Trust* [1999] ECC 167.

<sup>122</sup> See Meyers, above n.27, 258ff, and Miola, above n.7, 98 refers to *Pearce* as representing a „significant shift“ whilst Mason and Brodie, above n.48, 301 suggest that *Pearce* „introduces the reasonable patient standard of information disclosure as an acceptable part of English medical jurisprudence,“ and Michael A. Jones, „The Illogical Expert“ (1999) 15 *Professional Negligence* 117, 120 argues that the „importance of *Bolitho* lies in the now explicit requirement to undertake a logical analysis of the evidence rather than rely upon the eminence or number of experts expressing the particular view.“

their condition. All this despite the fact that she had come in to see the doctor because she was concerned about her health and that of her unborn child.

To some commentators the decision of *Bolitho* introduced the clarifying term of 'logical'. The Court must be satisfied that the treatment had a logical basis. Lord Woolf, writing extra-judicially, suggested that the decision, as a result of this apparent qualification of the *Bolam* test, is less deferential to the medical profession<sup>123</sup> and Jones has argued that it calls for closer scrutiny of expert witnesses,<sup>124</sup> whilst Meyers described it as a 'chink in the armour of *Bolam*'<sup>125</sup> and as representing a 'gloss on *Bolam*.'<sup>126</sup> This assessment is, however, overly optimistic and does not address the essence of the decision. As explained above, the decision both denies any relevance in the context of the giving of advice and fails to depart from the guiding hand of policy. And, as we have seen, it is a poorly enunciated policy which therefore fails to provide a clear or consistent guide for future decisions.<sup>127</sup>

The interpretation of *Pearce* as introducing a balance of power between the doctor and patient, is also open to challenge. The introduction of the term 'significant' has been described as a 'bold step away from *Sidaway* and *Bolam* and towards the standard found in Australia.'<sup>128</sup> Whilst the terminology on its own sounds promising, an analysis of the reasoning (as set out above) clearly demonstrates that what is significant continues to be determined by factors external to the patient. The patient is deemed completely unable to determine the significance of information for themselves. To the Court and the doctor significance is little more than a percentage likelihood; concepts such as severity of the risk of harm and potential impact on the patient (and

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<sup>123</sup> Lord Woolf, above n.82, 9.

<sup>124</sup> Michel A. Jones, „The Illogical Expert,“ (1999) 15 *Professional Negligence* 117, 117.

<sup>125</sup> Meyers, above n.27, 261.

<sup>126</sup> *Ibid*, 265.

<sup>127</sup> We will re-visit the policy question in some detail in Part III, Chapter 10.

<sup>128</sup> I.Kennedy and A.Grubb, *Medical Law* (3<sup>rd</sup> ed, Butterworths, London, 2000), 710. Also note Mason and Brodie, above n.48, 301 in which it is suggested that the case introduces the „reasonable patient standard“ and Jackson, above n.84, 276 suggests that *Pearce* modified the *Bolam* test be „emphasising the fact that medical opinion needs to be responsible and reasonable.“



their unborn child) are not relevant considerations. I argue this despite the assertion of Kennedy and Grubb<sup>129</sup> that the Court directed that significance is more than a mere percentage and that a 'significant risk need not be one which would have altered the patient's decision.'<sup>130</sup> In their view this meant that the patient's views were considered. But the Court, in fact, demonstrated a willingness to overlook the patient's view when it empowered the doctor to conclude that the patient simply would not have understood the information presented. This once again goes to the issue of incorrect focus: why was it not deemed to be a breach of duty of care that the doctor did not try to explain the potential risks to her unborn child<sup>131</sup> in a manner that she could understand? Surely it is the doctor's responsibility to take care to demystify and clarify treatment options and the mysteries of medical procedures?

We can see, therefore, that the general view of the pure *Bolam* test is one of general pessimism with commentators viewing it as a test protecting the medical profession, providing a minimal benchmark: wheel in an expert and the test is met. Some suggest that more recent decisions have brought more rigour to the process, whilst others say it redresses the imbalances, turning more attention to the patient. The question to consider now is: What is the practical reality?

### **The practical application of Bolam and Sidaway: A professional practice test**

[3.100] The reality is that the practical application of the *Bolam* test (even as clarified in more recent decisions) continues to be one based on a standard driven by the very profession under scrutiny. Such an approach is clearly in

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<sup>129</sup> Kennedy and Grubb, above n.128.

<sup>130</sup> Ibid, 709.

<sup>131</sup> At law the use of the term „child“ at this stage is incorrect as it is yet to be born and attain a legal identity. I have, however, deliberately chosen to use the term „unborn child“ because in Ms Pearce's mind, at that time, legal definitions would not have been relevant and „unborn child“ characterises the relationship that she had with the foetus.

conflict with basic principles of the tort of negligence. An early commentary on the *Bolam* decision recognised and analysed this problem by considering the question of negligence as an ethical or sociological concept.<sup>132</sup> In his discussion of the case, Montrose noted that conduct is not acceptable merely because others engage in it. A speeding motorist does not escape a claim in negligence merely because others speed on that road. This prompts the question, why then does a medical professional escape negligence merely because other medical professionals would act in the same way?<sup>133</sup>

The patient approaches the medical professional with certain expectations and these will generally include an expectation that their wants and needs will be taken into consideration. The law in the UK continues to fail to recognise this. At its simplest level, if a common (and accepted) medical practice is not to inform a patient, then the law does not expect that patient to be warned. At this point in the development of the law, there is no opportunity for the Court to turn to the patient and ask them, what would you consider a 'significant' risk? Ms Pearce would certainly have thought that risk of stillbirth was significant and Mrs Sidaway felt that nerve root damage was significant to her. Whilst these were opinions formed after the event, Mrs Pearce clearly was concerned about the welfare of her unborn child (which is why she approached the doctor in the first place) and Mrs Sidaway had, in fact, asked about the chance of paralysis. The Courts, however, held a different view, even going so far as to accept the argument that a pregnant woman is unable to understand the nature of risks to her unborn child.

It is interesting to note that whilst the Courts are protecting the medical profession, the profession itself is tightening its standards. The General Medical Council (GMC) provides guidelines for professional behaviour and in its Guideline on seeking patients' consent has moved away from the

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<sup>132</sup> J.L. Montrose „Is Negligence an Ethical or Sociological Concept?“ (1958) 21 *Modern Law Review* 259.

<sup>133</sup> *Ibid.*

position adopted by the Courts.<sup>134</sup> There is no reference to the phrase 'informed consent' in the Guidelines<sup>135</sup> and the emphasis is on the nature of the doctor/patient relationship which is viewed as a partnership. Of note is the requirement that no-one else besides the competent patient can make decisions about their treatment,<sup>136</sup> and the description of the process as individual and focussed on the making of 'informed decisions'<sup>137</sup> as opposed to 'informed consent.' A final point of note in the Guidelines is the assertion that doctors must avoid making 'assumptions about a patient's understanding of risk or the importance they attach to different outcomes.'<sup>138</sup> Thus an application of the Guidelines to the approach adopted by Mrs Pearce's doctor would perhaps find that he failed to meet the requisite standard of care as he made clear assumptions regarding her ability to understand and absorb advice he might give her. An intriguing juxtaposition is now revealed: the professional standards which will be used to measure the duty of care expected of the doctor may well be set at a higher level than the legal standard which is said to be based on the professional standards. At the time of writing professional standards are yet to make an appearance in either the Court of Appeal or the House of Lords so it will be interesting to see how they will be reconciled with the legal standard as enunciated in the decisions discussed here.

Returning to the legal standard as expressed in *Bolam* and subsequent decisions, the practical effect is that the '*Bolam* test' focuses on matters outside the immediate concern of the patient. The doctrine of informed consent is clearly rejected and policy considerations continue to drive the Courts. But is

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<sup>134</sup> General Medical Council, *Consent: patients and doctors making decisions together (Guidance for doctors)*, [http://www.gmc-k.org/guidance/ethical\\_guidance/consent\\_guidance\\_index.asp](http://www.gmc-k.org/guidance/ethical_guidance/consent_guidance_index.asp) at 20 January 2011.

<sup>135</sup> Although it was a phrase which was entrenched in earlier Guidelines (replaced in 2008).

<sup>136</sup> *Ibid*, para 13.

<sup>137</sup> *Ibid*, para 28. This approach accords with the recommendation of the process being referred to as informed choice as opposed to informed consent, in both the GMC Guidelines and my argument (to be explored further in Part III) the focus is on the process of obtaining and processing information as opposed to the mechanics of agreeing to a particular course of treatment.

<sup>138</sup> *Ibid*, para 31.

the outcome significantly different from what would happen in either the United States or Australia?

### **Re-visiting the core issues**

[3.110] Returning once again to our three main questions we will see that despite claims that the position in the United Kingdom is grounded in a straightforward professional practice test,<sup>139</sup> this is not always the case. The application of the *Bolam* test has been subject to ongoing judicial and scholarly debate with the result being a variable standard and a situation that is no clearer than that found in the United States (which the UK Courts emphatically reject) or Australia (which has, in turn, emphatically rejected the position in the United Kingdom).

#### *Is 'informed consent' truly about consent?*

[3.120] Jones has suggested that 'it is a misnomer to talk of informed consent since a patient's right to the information which will enable him [or her] to make a meaningful choice about the treatment options depends upon the doctor's duty to exercise reasonable care in performing his [or her] professional functions as a doctor.'<sup>140</sup> Similarly, Lord Donaldson in the Court of Appeal stepped back from consent when he pointed out that 'it is not a matter of English law that a failure to give sufficient information will vitiate consent.'<sup>141</sup> The focus in all of the discussions (both judicial and scholarly, as outlined above) is on the quality of advice given by the doctor as measured by professional standards. As well as referring to 'informed consent' as a 'misnomer', Jones, went on to explain that the 'Courts in the UK have, to a large extent, separated ... doctors duty and patient's rights, principally to

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<sup>139</sup> See for example the comments in *Rogers v Whitaker* (1992) 175 CLR 479, 489 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

<sup>140</sup> Jones, above n.56, [6-105].

<sup>141</sup> *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1984] QB 493, 511 (Lord Donaldson).

curtail actions for battery against medical practitioners,<sup>142</sup> thus indicating a retreat from consent issues.

If the legal test is not about consent then we must determine what it truly is (or ought to be) about. In *Chester*<sup>143</sup> Lord Walker took some steps towards clarifying the law when he noted that whilst the test is not specifically about consent, the provision of advice is the ‘foundation of consent,’<sup>144</sup> a position which is perhaps reflected in the GMC Guidelines on ‘consent’ which are labelled ‘consent’ but address the concept of informed decisions which are the precursor to the consent to (or of course, refusal of) medical treatment.<sup>145</sup> It is best therefore to avoid the language of consent and talk instead of the quality of the advice given to and the ability of the patient to make an informed choice or informed decision.

***Who takes the central role (the prudent patient or the prudent professional)?***

[3.130] As we have seen, the United Kingdom is traditionally identified as the jurisdiction most focussed on the professional standards of the doctor (as established by his or her peers). It is this perception which drove the rejection of the *Bolam* test by the *Rogers v Whitaker*<sup>146</sup> Court and Lord Scarman’s dissenting judgment in *Sidaway*.<sup>147</sup> There have been claims of a shift in focus back to the patient as demonstrated by *Pearce*<sup>148</sup> and this is supported by some more recent judicial statements, such as that of Lord Steyn in *Chester* when he adopted language reminiscent of Cardozo’s in *Schloendorff*<sup>149</sup> and referred to the ‘starting point ... that every individual of adult years and sound mind has

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<sup>142</sup> Jones, above n.56, [6-105].

<sup>143</sup> *Chester v Afshar* [2005] 1 AC 134.

<sup>144</sup> *Ibid*, 165 (Lord Walker).

<sup>145</sup> General Medical Council, *Consent: patients and doctors making decisions together (Guidance for doctors)*, [http://www.gmc-uk.org/guidance/ethical\\_guidance/consent\\_guidance\\_index.asp](http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp) at 20 January 2011.

<sup>146</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 489.

<sup>147</sup> *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1985] AC 871, as outlined above.

<sup>148</sup> *Pearce v United Bristol Healthcare NHS Trust* [1999] ECC 167, refer discussion and references above n.92.

<sup>149</sup> *Schloendorff v The Society of the New York Hospital* 105 NE 92 at 93 (1914).

a right to decide what may or may not be done with his or her body.<sup>150</sup> He then proceeded to refer specifically to the notion of autonomy and the imperative that 'due respect is given to autonomy and dignity of each patient.'<sup>151</sup> As argued above however, I reject these claims and argue that the doctor continues to sit firmly at the heart of the debate and it truly is an enquiry which focuses on the prudent professional.

*Are we dealing with patient autonomy or professional standard of care? (Or is it about the doctor or the patient?)*

[3.140] It follows directly from the answer to the previous question that the enquiry as it stands is emphatically one of professional standard of care. *Chester* demonstrates some attempt by the judiciary to shift focus to the autonomous patient but, as we will see in Part II when we consider causation, this attempt is confounded because under the existing framework, fundamental causative principles need significant massaging in order to meet the stated aims of the Court.

It is important to remember that in the United Kingdom, despite Lord Steyn's acknowledgment of the 'correlative rights and duties of the patient and surgeon,'<sup>152</sup> there is a clear distinction between the two.<sup>153</sup> This separation of the right of the patient to information from considerations of the doctor's professional standard remains constant throughout all of the judgments. Thus it is clear that the enquiry centres on a professional standard of care.

As with the situation in the United States, we see in the United Kingdom that each of the questions posed is open to some debate. There is more consistency in the United Kingdom than in the United States (perhaps

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<sup>150</sup> *Chester v Afshar* [2005] 1 AC 134, 143 (Lord Steyn).

<sup>151</sup> *Ibid*, 144.

<sup>152</sup> *Chester v Afshar* [2005] 1 AC 134, 143 (Lord Steyn).

<sup>153</sup> This point is clearly made by Jones, above n.56, and discussion above Is „informed consent“ truly about consent? (at [3.120]).

reflective of the consistency of jurisdiction as opposed to the multiple jurisdictions in the United States) but there continues to be judicial discomfort and ongoing debate regarding the true focus of enquiries involving the provision of pre-treatment advice ('informed consent'). I suggest, once again, that this is due to the attempts to combine disparate concepts in the one enquiry. There is an attempt to: utilise the language of consent (best suited to a trespass enquiry), address the question of professional standards (which are measured by other members of the same profession) and the infringement of a personal right to information. This cannot, and does not, result in coherent law. The focus ought to be on the individual concerned and the affected process, not consent or professional standards.

## Chapter 4: Australia

### Introduction

[4.10] We will now turn our attention to the last of our triumvirate of jurisdictions, Australia. It is fitting that this is the final jurisdiction to be considered in this section of our discussion because the High Court has respectfully, but firmly, distinguished its position from that of both the United States and the United Kingdom, highlighting the ‘shortcoming(s) of *Bolam*’<sup>1</sup> and describing the use of terms such as ‘self-determination’ and ‘informed consent’ (as represented by *Canterbury*) as ‘amorphous’ and ‘unhelpful.’<sup>2</sup> The position in Australia, as exemplified by the decision of *Rogers v Whitaker*,<sup>3</sup> has been hailed as a ‘defining moment’ in Australian medical jurisprudence<sup>4</sup> providing a ‘concise statement of the law’<sup>5</sup> which reflects a consistency between medical law and sound legal and ethical principles.<sup>6</sup> Equally, it has been described as imposing an ‘onerous burden’ on doctors<sup>7</sup> and has been subject to ‘significant criticism.’<sup>8</sup> This part of our discussion will analyse the decision in *Rogers v Whitaker*, unravel the commentary and investigate the true nature of the test.

In completing the profile of the different approaches to standard of care it will become clear that despite the ongoing debate regarding the appropriate test, Miola was correct when he suggested that ‘*Rogers* and *Sidaway*’ are

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<sup>1</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 481 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

<sup>2</sup> *Ibid*, 490.

<sup>3</sup> (1992) 175 CLR 479.

<sup>4</sup> J. Devereux, „It’s Just a Jump to the Left – and then a Step to the Right: Developments post *Rogers v Whitaker* in the Law Relating to the Failure by a Medical practitioner to Advise of Risks,” (1998) 17 *University of Tasmania Law Review* 63, 64.

<sup>5</sup> T. Addison, „Negligent Failure to Inform: Developments in the law since *Rogers v Whitaker* „, (2003) 11 *Tort Law Journal* 165, 167.

<sup>6</sup> J. Keown, „Burying *Bolam*: Informed Consent Down Under,” [1994] *Cambridge Law Journal* 16.

<sup>7</sup> R. Mulheron, „Twelve Tests to Identify Whether a Medical Risk is “Material”” (2000) *National Law Review* 1, [97].

<sup>8</sup> I. Kerridge, M. Lowe & C. Stewart, *Ethics and Law for the Health Professions* (2009, Federation Press, Sydney), 306. The authors refer the reader to D. Mendelson, „Liability for Negligent Failure to Disclose Medical Risk” (2001) *Journal of Law and Medicine* 335.



‘more similar than different’<sup>9</sup> (and I would add that *Canterbury* is also similar in outcome). All three travel a different path of judicial reasoning but all arrive at the same point. This conclusion will be supported by a return to our discussions about Sally. I will apply the three different tests to her situation and we will see that the same conclusion is reached. This then raises the additional question of why is this test so troubling and why, despite the considerable judicial concern and effort, does it continue to be problematic? This in turn raises the additional question of why does this debate continue? I suggest that it is symptomatic of the troubling nature of the ‘informed consent’ doctrine which is, quite simply, asking the wrong question. The judicial scrutiny should be of the process of choice, not consent.<sup>10</sup>

### **The foundations of ‘informed consent’<sup>11</sup>: *Rogers v Whitaker* – The decision**

[4.20] In Australia, as in the United States and the United Kingdom, the issue of consent in the context of medical treatment has long been viewed as appropriately governed by the law of negligence, with decisions turning on the standard of care required of medical practitioners. Until the decision of *Rogers v Whitaker*, that standard in Australia was governed by the ‘*Bolam* principle,’<sup>12</sup> but it was not without its critics. The basis of judicial criticism was that it enabled the medical profession to be the arbiter of what constituted negligent behaviour, an approach that was inherently risky. This concern was given full voice in *Rogers v Whitaker* but was foreshadowed in the earlier decision of *F v R*<sup>13</sup> with the Court recognising that professions may well adopt unreasonable practices which develop to

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<sup>9</sup> J. Miola, „On the Materiality of Risk: Paper Tigers and Panaceas“ (2009) 17 *Medical Law Review* 76, 99.

<sup>10</sup> This is, of course, the central theme of my thesis and it is one to which we will return as we progress.

<sup>11</sup> The term „informed consent“ is placed in inverted commas here to highlight the fact that the foundations of the doctrine in Australia lay in a clear denial of its relevance as a term.

<sup>12</sup> Refer *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, as outlined above in Chapter 3.

<sup>13</sup> (1989) SASR 189.

serve the needs of the profession rather than the client (or in these circumstances the patient). King CJ called for judicial scrutiny of professional practices to ensure that they accord with the requirements of the law.<sup>14</sup> The High Court in *Rogers v Whitaker*, endorsed *F v R* and specifically affirmed the relevance of the factors set out by King CJ.<sup>15</sup> These 'factors' were collectively described as 'relevant circumstances' and said to 'include the nature of the matter to be disclosed, the nature of the treatment, the desire of the patient for information, the temperament and health of the patient and the general surrounding circumstances.'<sup>16</sup> It was upon this foundation that the High Court then built the materiality test and rejected the *Bolam* approach of allowing the medical profession to set the standard of care as 'illogical'.<sup>17</sup> We see then an addressing of some of the concerns highlighted in Chapter 3, and a clear intention to bring a clarity to the debate. We will also see however that subsequent interpretations of this decision, many of them scholarly, have meant that its full vigour and rejection of the 'mistakes' of other jurisdictions is not given practical effect.

The facts of *Rogers v Whitaker* are well known. Mrs Whitaker had been almost totally blind in the right eye for many years (the result of a penetrating injury when young) and under medical advice she chose to undergo a corrective procedure. During discussions with the surgeon she clearly exhibited concern about her left eye but did not ask specific questions about sympathetic ophthalmia, a condition which was deemed to have a risk of one in 14,000. Unfortunately the risk eventuated, she developed sympathetic ophthalmia and was almost completely blind as a result. She sought compensation on the grounds of negligence. Dr Rogers contested her claim arguing that the accepted practice was not to inform patients of this risk. The Court rejected his position which was consistent with the *Bolam* test, instead introducing a test of 'materiality' based on what

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<sup>14</sup> *F v R* (1983) SASR 189, 193-194. (King CJ).

<sup>15</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 491 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

<sup>16</sup> *F v R* (1983) SASR 189, 192 (King CJ).

<sup>17</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 489 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

the patient would want to know as opposed to what the medical profession deemed to be relevant.<sup>18</sup> Echoing the language of the *Canterbury* Court, the High Court found that a duty of care will be breached unless the doctor informs the patient of all material risks. The Court stated that:

a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risks would be likely to attach significance to it.<sup>19</sup>

In shifting the focus from the perspective of the medical profession to that of the patient, the decision has been said to emphasise the importance of self-determination and autonomy in the realm of medical consent, the result being an introduction of the notion of informed consent.<sup>20</sup> This interpretation is despite clear statements by the Court that the decision is not about consent. According to the High Court, the question of consent is relevant only in the context of battery and battery is negated by the patient being advised in broad terms of the nature of the procedure to be performed.<sup>21</sup>

The majority judgment<sup>22</sup> was quite clear in its rejection of notions of informed consent and autonomy. The focus was on provision of negligent advice which turned on the question of scope and content of duty in this context.<sup>23</sup> It was emphasised that the existence of a duty of care was never in question, and neither was the standard of care which was accepted as that

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<sup>18</sup> Ibid, 490.

<sup>19</sup> Ibid.

<sup>20</sup> I will explore the scholarly interpretations of *Rogers v Whitaker* further below but it is worth noting Miola's suggestion that after *Rogers* „patient autonomy seemed alive and well, and doctors should be quaking in their boots,“ Miola, above n.9, 93.

<sup>21</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

<sup>22</sup> Mason CJ, Brennan, Dawson, Toohey and McHugh JJ presented the joint judgment which has been viewed as offering the authoritative position on consent in medical treatment cases.

<sup>23</sup> *Rogers v Whitaker* (1992) 175 CLR 479 , 483 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

enunciated in *Bolam*.<sup>24</sup> Informed consent, autonomy and self-determination were described as 'amorphous' and 'apt to mislead.'<sup>25</sup> Such terms were deemed to be relevant with respect to questions involving trespass and validity of consent, issues which, in the view of the Court, had no place in this decision.

An interesting distinction was drawn in the judgment between consent for the purposes of trespass that can, in the view of the Court, be 'meaningless', because it is made in the absence of relevant information and advice, and meaningful choice (or agreement) to proceed with treatment.<sup>26</sup> On this basis there are, according to *Rogers v Whitaker*, two levels of decision making. First there is the process of 'meaningless consent' which, it would seem, is sufficient to defeat trespass. Then there is a second stage of meaningful 'choice' which, despite depending upon quality of advice and information, is viewed as a different legal creature from informed consent.

The question then is what, according to the Court, makes choice meaningful? It is clear that it is about the exchange of information with a focus on the needs and wishes of the patient, as opposed to the professional judgment of the doctor. The main criticism of the *Bolam* principle was that it was interpreted as removing the decision-making power from the judiciary and placing it in the hands of the very profession which was under review. This position marks the apparent point of departure from *Bolam* with the focus shifting from the prudent doctor to the prudent patient and a consideration of what the patient, as opposed to the doctor, would deem material.

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<sup>24</sup> *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582. The standard being that of reasonable care and skill of the ordinary skilled person exercising and professing to have that special skill (*Rogers v Whitaker* (1992) 175 CLR 479, 482, (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ). This position affirmed the earlier statement in *F v R* (1989) 33 SASR 189, 190 (King CJ).

<sup>25</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

<sup>26</sup> *Ibid.*

It is no coincidence therefore that the theme of choice is at the heart of this thesis.<sup>27</sup> It is important at this point in our discussion to emphasise the High Court's endorsement of the significance of choice and rejection of notions of consent. The Court spent some time considering (and rejecting) the *Bolam* test. As a starting point, the majority of the High Court declared the provision of professional advice and the provision of treatment to be a single comprehensive duty.<sup>28</sup> Yet the Court went on to find that factors used to determine the content of duty in the different components of advice and treatment would vary according to circumstances. The result was that, despite endeavouring to identify a 'single comprehensive duty' the different aspects of the therapeutic relationship were clearly separated, with the *Bolam* standard maintaining authority in the context of diagnosis and treatment.<sup>29</sup> The provision of pre-treatment advice was specifically separated from diagnosis and treatment and the test of materiality was devised in order to provide content to the duty of care and to give meaning to patient choice.

In short, the decision of *Rogers v Whitaker* was, according to the Court, about the content of the duty of care owed by doctors to their patients when giving advice regarding proposed treatment. Advice that covered material risks (with materiality being determined from the patient's perspective) would infuse the choice with meaning or, to put it more succinctly, enable informed choice. This was not, according to the majority, a decision about standard of care in the context of diagnosis and treatment, the notion of self-determination or informed consent. It was about choice.

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<sup>27</sup> A theme which is more specifically developed in Part III.

<sup>28</sup> *Ibid*, 489.

<sup>29</sup> As outlined in Chapter 3, fn. 90 this is now legislatively endorsed in most Australian jurisdictions.

## Interpretations of *Rogers v Whitaker*

### *The Courts*

[4.30] The judicial acceptance of *Rogers v Whitaker* has proved unproblematic, and unlike the ongoing debates in both the United States and the United Kingdom, the test has been readily addressed and endorsed.<sup>30</sup>

The authority of *Rogers v Whitaker* and significance of the materiality test were reinforced by the High Court in *Chappel v Hart*<sup>31</sup> and *Rosenberg v Percival*,<sup>32</sup> with both decisions focussing on the nature of the risk and the needs of the respective plaintiffs.<sup>33</sup> This approach has been consistent across Australian state jurisdictions with two additions: considerations of the autonomous individual and the use of the phrase ‘informed consent’. The inclusion of both of these concepts (which the High Court clearly rejected), signal a subtle, but important, shift away from the basic principles of *Rogers v Whitaker* and perhaps towards either (or both) the approaches in the United States and the United Kingdom. The brief discussion that follows is a mere snapshot of the judicial application of *Rogers v Whitaker* but provides insight into the three key points I would like to make: the test is applied in a straightforward manner, autonomy is perceived as the foundation of the *Rogers v Whitaker* test and the language of informed consent is alive and well.

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<sup>30</sup> A basic „CaseBase“ search returns in excess of 250 decisions either applying or considering *Rogers v Whitaker* (1992) 175 CLR 479. Search term was case name „Rogers v Whitaker“ <http://www.lexisnexis.com/au/legal>, 14<sup>th</sup> December 2011.

<sup>31</sup> (1998) 195 CLR 232.

<sup>32</sup> (2001) 205 CLR 434.

<sup>33</sup> Both of these decisions turned on the question of causation and will therefore be considered in more detail in Part II.

## Applying the test

[4.40] The principles espoused in *Rogers v Whitaker* remain unchallenged in the lower Courts. The Queensland Supreme Court referred to the ‘unproblematic application of the materiality test’<sup>34</sup> and in New South Wales Basten JA referred to the ‘well established principle’ of *Rogers v Whitaker*.<sup>35</sup> Similarly, in the Western Australian Court of Appeal, Martin CJ explained that he had ‘no difficulty in principle with the notion of a medical practitioner having a duty to warn ...’ and referred to the ‘well-established duty’ citing *Rogers v Whitaker* as authority.<sup>36</sup> The significance of the earlier decision of *F v R*<sup>37</sup> has also been acknowledged with the factors outlined by King CJ<sup>38</sup> and endorsed by the High Court,<sup>39</sup> providing the structure for decisions in lower Courts.<sup>40</sup> It is worth noting that the impact of *Rogers v Whitaker* on medical practice has also been emphasised, with McCallum J in the Supreme Court of New South Wales using *Rogers* to reject evidence that advice was not given when he stated that he found it ‘inherently unlikely that in 1996, four years after *Rogers*, an experienced orthopaedic surgeon would not give a warning.’<sup>41</sup>

It is also noteworthy that the materiality test has been interpreted as having two limbs. Jones DCJ referred to the ‘proactive’ and ‘reactive’ stages of the enquiry,<sup>42</sup> with the consideration of the reasonable person in the patients’ position forming the ‘proactive’ stage and the question of what the doctor knew, or ought to know, that the particular patient would attach significance to, forming the reactive.<sup>43</sup> Similarly, in the New South Wales

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<sup>34</sup> *Ormsby v Stewart & Ors* [2009] QSC 200, [45] (Martin J).

<sup>35</sup> *Ellbourne v Gibbs* [2006] NSWCA 127, [54] (Basten JA).

<sup>36</sup> *Hammond v Heath* [2010] WASCA 6, [16].

<sup>37</sup> *F v R* (1983) 33 SASR 189.

<sup>38</sup> Nature of the matter to be disclosed, nature of the treatment, patient’s desire for information and the patient. *F v R* (1983) 33 SASR 189, 192-3.

<sup>39</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 491 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

<sup>40</sup> See for example, *Coppolina v Kierath* [2003] WADC 141, [4] (Groves DCJ), *Monument v Baker* [2007] WADC 164.

<sup>41</sup> *Harris v Bellemore* [2010] NSWSC 176, [126] (McCallum J).

<sup>42</sup> *Adams v Hertess* [2010] QDC 369, [21].

<sup>43</sup> *Ibid.*

Court of Appeal, Santow JA referred us to the ‘subjective and objective aspects of material risk.’<sup>44</sup> There are numerous other examples of the basic application of the materiality test and acceptance of the approach of the High Court but this small collection of more recent decisions demonstrates that the nature of the test for duty of care, as enunciated in the High Court in *Rogers v Whitaker* remains unchallenged and is consistently applied. But is the actual ‘spirit’ of the principle applied with equal consistency? That is, have Australian Courts turned their face from issues of autonomy and informed consent in the context of pre-treatment advice? We will see, from the discussion below, that not only is this not the case but the point of departure from both the United States and the United Kingdom will also prove to be illusory.<sup>45</sup>

#### Reference to autonomy

[4.50] As we have seen, the High Court clearly and unambiguously, removed itself from considerations of autonomy or ‘self-determination,’<sup>46</sup> preferring instead to focus on the process of information exchange and the duty of the doctor. Subsequent decisions have not been as careful in their avoidance and have viewed considerations of autonomy as the basis of the principles espoused in *Rogers v Whitaker*. Most notable of these is Kirby J, in the High Court when he asserted that ‘fundamentally the rule [in *Rogers v Whitaker*] is a recognition of individual autonomy.’<sup>47</sup>

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<sup>44</sup> *Johnson v Biggs* [2000] NSWCA 338, [93] (Santow AJA). This is consistent with the recommendations contained within the „Review of the law of Negligence Final Report“, Sep 2002 („The Ipp Report“) [http://revofneg.treasury.gov.au/content/Report2/PDF/Law\\_Neg\\_Final.pdf](http://revofneg.treasury.gov.au/content/Report2/PDF/Law_Neg_Final.pdf), at 18 February 2011. Recommendation 7 specifically refers to the proactive and reactive elements of the doctor’s duty and the proactive duty to inform is specifically covered [3.51]-[3.64] and the reactive [3.65]-[3.70]. As this has no specific relevance to this discussion beyond highlighting of the different components of the test there is no need to consider it in any further detail here.

<sup>45</sup> This final point of the argument is discussed in detail in *The more things change, the more they stay the same* (at [5.10]).

<sup>46</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

<sup>47</sup> *Rosenberg v Percival* (2001) 205 CLR 434, 480 (Kirby J).



It is unsurprising then that at State level, *Rogers v Whitaker* has been aligned with the protection of autonomy. In *Hookey v Paterno*, we are referred to the ‘concept of autonomy’ as the driving force behind the requirement for the Courts to ‘adjudicate the standard of care’ (and *Rogers v Whitaker* is cited as authority for this proposition).<sup>48</sup> In *Dr Ibrahim v Arkell*, Fitzgerald JA explains the rationale behind the ‘very high’ duty as the ‘policy requirement entitling a competent person to make his or her own decision about his or her life.’<sup>49</sup> A more specific reference to the principle of autonomy can be found in other decisions: in *Harris v Bellemore* there is reference to ‘the primacy of autonomy’<sup>50</sup> and in *Tann v Benkovic* Mason P specifically states that ‘the duty of care of *Rogers* is premised on the notion of autonomy.’<sup>51</sup>

It is clear therefore that, whilst not every decision specifically refers to autonomy, it continues to be a relevant consideration which the Courts view as inherent in the right to information. Significantly, reference to autonomy in the context of pre-treatment advice is present in the High Court (in *Rosenberg v Percival*) and this provides authority for it to be considered in the lower Courts. It is therefore a concept which, despite being rejected by the *Rogers* Court, is now viewed as not only present in the principles of *Rogers v Whitaker* but as being the basic premise of the duty as espoused in that decision. The ‘amorphous and unhelpful’<sup>52</sup> has become a ‘policy requirement’<sup>53</sup> and a ‘primary concern’<sup>54</sup> that is fundamental to any consideration of pre-treatment advice.

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<sup>48</sup> *Hookey v Paterno* [2009] 22 VR 362, [224] (Neave JA).

<sup>49</sup> *Dr Ibrahim v Arkell* [1999] NSWCA 95, [33] (Fitzgerald JA).

<sup>50</sup> *Harris v Bellemore* [2010] NSWSC 176, [81] (McCallum J).

<sup>51</sup> *Tan v Benkovic* [2000] 51 NSWLR 295, [29] (Mason P).

<sup>52</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

<sup>53</sup> *Dr Ibrahim v Arkell* [1999] NSWCA 95, [33] (Fitzgerald JA).

<sup>54</sup> *Harris v Bellemore* [2010] NSWSC 176, [81] (McCallum J).

## The role of 'informed consent'

[4.60] As reflected in the title of this thesis, I believe that despite the High Court's rejection of the phrase 'informed consent', it continues to have currency as a term. We will see this more clearly in Part II and the exploration of causation which clearly turns on the question of consent. For the moment however, it is worth noting the acceptance of the term. It is rare in the lower Courts to see judicial use of the phrase 'informed consent' and yet it is not rejected when plaintiffs frame their complaint in the language of informed consent. In *Ormsby v Stewart & Ors*,<sup>55</sup> the statement of claim referred to the duty of care of the doctor to give information in the context that the plaintiff had failed to give informed consent. Similarly, in *Kerr v Minister for Health*<sup>56</sup> the claims raised by the plaintiff included an assertion that in the absence of appropriate advice, she did not give informed consent and in *Coppolina v Kierath*,<sup>57</sup> Groves DCJ in explaining the evidence and the cross-examination of the plaintiff noted that it 'was in large part, directed towards pre-operative informed consent.'<sup>58</sup>

Thus whilst the term informed consent is generally avoided by the judiciary it is used in common parlance and in the framing of claims and, as shown in the small collection of cases above, this language is not challenged by the judiciary. This interpretation is supported by Kirby J's considered judgment in *Rosenberg v Percival*.<sup>59</sup> His Honour clearly acknowledged that whilst there is no place for informed consent in Australian jurisprudence, the issues addressed by the materiality rule are those most commonly associated with informed consent in both legal and medical literature.<sup>60</sup> It is this continued reliance on, and reference to, concepts of consent that make the principles of

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<sup>55</sup> *Ormsby v Stewart & Ors* [2009] QSC 200.

<sup>56</sup> *Kerr v Minister for Health* [2009] WASCA 27.

<sup>57</sup> *Coppolina v Kierath* [2003] WADC 141.

<sup>58</sup> *Ibid*, [42] (Groves DCJ). Also see *Wallace v Ramsay Health Care Ltd* [2010] NSWSC 18 [35] where Harrison J, in setting out the plaintiffs submission referred specifically to the „notion of informed consent.“

<sup>59</sup> (2001) 205 CLR 434.

<sup>60</sup> *Ibid*, 476.

*Rogers v Whitaker* difficult to apply in practice. The decision itself sought to focus on the process of communication and choice but, as we will see in the next part of our discussion,<sup>61</sup> it is the principle of consenting to (or refusal of) treatment that truly drives, and I suggest misdirects, the enquiry.

### *The scholarly view of Rogers v Whitaker*

[4.70] Turning now to the scholarly interpretations of *Rogers v Whitaker*, we will see that a similar pattern emerges with both informed consent and autonomy playing a pivotal role in discussions. Despite the best efforts of the High Court, *Rogers v Whitaker* continues to be associated with informed consent.<sup>62</sup> It has been described as ‘a simply-articulated version of the American rule of informed consent’<sup>63</sup> and a ‘consideration of the process of informed decision-making.’<sup>64</sup> Similarly, there is a scholarly endorsement of autonomy as the foundational principle of ‘informed consent’ and an overriding view that *Rogers v Whitaker* and *Rosenberg v Percival* combine to ‘embed the primacy of autonomy for patient decision-making’ in the law.<sup>65</sup>

### **Reference to autonomy**

[4.80] The overarching theme of the scholarly literature entails a recognition of the authority of *Rogers v Whitaker* (as endorsed in both *Rosenberg v Percival* and *Chappel v Hart*), coupled with an acceptance of autonomy (or self-determination) as the foundational principle. Gottlieb and Linden for

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<sup>61</sup> See Part II: In search of the missing link - Causation.

<sup>62</sup> See for example D. Chalmers and R. Schwarz, „Rogers v Whitaker and Informed Consent in Australia: A Fair Dinkum Duty of Disclosure“ [1993] 1 *Medical Law Review* 139, 139 where we are informed that in *Rogers v Whitaker* the „High Court has presented Australia with the strongest and most patient-oriented doctrine of informed consent among the common law jurisdictions.“ We also see *Rogers v Whitaker* emphatically aligned with informed consent in the title of articles, such as Hon David K. Malcolm, AC „The High Court and Informed Consent: The Bolam principle Abandoned“ (1994) 2 *Tort law Review* 81 and J. Keown, „Burying Bolam: Informed Consent Down Under“ [1994] *Cambridge Law Journal* 16. Indeed, the Australian Institute of Health Law and Ethics (as it was then called, the organisation now forms a part of Australasian Association of Bioethics and Health Law, AABHL) hosted a 10<sup>th</sup> Anniversary salute to *Rogers v Whitaker* entitled „Informed Consent in Australia – Tenth Anniversary of *Rogers v Whitaker*‘ (26 October 2002).

<sup>63</sup> D. Chalmers and R. Schwarz, „Rogers v Whitaker and Informed Consent in Australia: A Fair Dinkum Duty of Disclosure“ [1993] 1 *Medical Law Review* 139, 145.

<sup>64</sup> Devereux, above n.4 69.

<sup>65</sup> I. Freckelton, „*Rogers v Whitaker* Reconsidered“ (2001) 9 *Journal of Law and Medicine* 5, 6.

example discussed *Rosenberg* and emphasised the significance of autonomy,<sup>66</sup> and in a similar vein to my thesis, Mendelson referred to the 'dignitary harm to the patient's autonomy in being deprived of making a meaningful choice.'<sup>67</sup> Waddams also described the failure to inform (as addressed by *Rogers v Whitaker*) as leading to 'an infringement of the patient's autonomy'<sup>68</sup> and Addison referred to 'self-determination as the paramount consideration in *Rogers v Whitaker*.'<sup>69</sup>

More recently, Miola commented that 'after *Rogers v Whitaker* patient autonomy seemed alive and well, and doctors should be quaking in their boots.'<sup>70</sup> Ross took the argument one step further when he not only recognised the significance of autonomy in the *Rogers v Whitaker* decision, but argued that the '*Rogers* decision has promoted a form of mandatory autonomy.'<sup>71</sup> Further insight into the scholarly view was given by Malcolm who explained that the information supplied by the doctor is the basis for the decision and represents the patients' 'only moment of self-determination',<sup>72</sup> and other scholars have referred to autonomy as the 'purpose'<sup>73</sup> and the 'justification'<sup>74</sup> for the duty to inform. This review of the scholarly literature could continue but rather than become mired in a recount of the arguments of others, I have chosen to simply highlight the ongoing acceptance of autonomy as the foundational principle of the duty to inform. My point here is that despite the High Court's assertion that

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<sup>66</sup> J. Gottlieb & S.Linden, „*Rosenberg v Percival – Rogers v Whitaker* revisited“ (2001) 9(8) *Australian Health Law Bulletin* 69, 72.

<sup>67</sup> D. Mendelson, „The Breach of Medical Duty to Warn and Causation: *Chappel v Hart* and the necessity to reconsider some aspect of *Rogers v Whitaker*“ (1998) 5 *Journal of Law and Medicine* 312. Mendelson further points to the nature of the loss suffered and describes the nature of the physical harm, which is the focus of the causation enquiry, as „consequential“ as opposed to „primary“ (I take this one step further and describe it as logically irrelevant). We will explore these themes further in Part II of the thesis when we follow the ongoing search for the missing causal link.

<sup>68</sup> S.M. Waddams, „Causation, physicians and disclosure of risks“ [1997] *Tort Law Review* 5, 7.

<sup>69</sup> T. Addison, „Negligent Failure to Inform: Developments in the law since *Rogers v Whitaker*“ (2003) 11 *Torts Law Journal* 165, 167.

<sup>70</sup> Miola, above n.9, 93.

<sup>71</sup> A. Ross, „A Public perspective of *Rogers v Whitaker*“ paper presented at the AIHLE Conference: Informed Consent in Australia – Tenth Anniversary of *Rogers v Whitaker* held at ANU 26 October 2002, 1.

<sup>72</sup> Hon D. Malcolm, AC, „The High Court and Informed Consent: The *Bolam* principle Abandoned“ (1994) 2 *Tort Law Review* 81, 92.

<sup>73</sup> M. Stauch, „Taking the Consequences for Failure to Warn of Medical Risks“ (2000) 63 *The Modern Law Review* 261, 268.

<sup>74</sup> P. Cane, „A Warning about Causation“ (1999) 115 *Law Quarterly Review* 21, 24.

*Rogers v Whitaker* represented a rejection of the transatlantic language and notions of self-determination, the scholarly literature (and as we have seen the Australian judiciary), have chosen to adopt it.

### *The role of 'informed consent'*

[4.90] Any review of the scholarly discussions of *Rogers v Whitaker* and associated cases reveals a ready acceptance of the term 'informed consent' to cover the core principles of the decisions. Some of these have already been highlighted<sup>75</sup> and further illustrations can be found. These are worth briefly considering as they provide insight into the more common interpretations of the principles espoused in *Rogers v Whitaker*. Consider Freckelton for example, whilst he did not specifically adopt the term himself, he referred to it through his consideration of the criticisms of *Rogers v Whitaker* as set out in *Rosenberg v Percival* which he described as being 'about informed consent.'<sup>76</sup> The term informed consent is embedded in the work of Olbourne who asserts that 'the floodgates of informed consent litigation do appear to be opening.'<sup>77</sup> Then of course, as highlighted in our earlier discussions, Chalmers and Schwarz describe *Rogers v Whitaker* as presenting Australia 'with the strongest and most patient-oriented doctrine of informed consent among the common law jurisdictions,' and also suggest that perhaps the 'High Court was over-zealous to distinguish itself [from the United States]'.<sup>78</sup>

Whilst the majority of scholars tend to accept the term 'informed consent' and express a willingness either to put the High Court's rejection of it to one side or to simply ignore it, this is not a uniform approach. Mendelson, for example, expresses concern and argues that 'by rejecting the informed

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<sup>75</sup> See above, n.62, n.63 and 64.

<sup>76</sup> Freckelton, above n.65

<sup>77</sup> N. Olbourne, „The Influence of *Rogers v Whitaker* on the Practice of Cosmetic Plastic Surgery“ 5 *Journal of Law and Medicine* 334, 346.

<sup>78</sup> Chalmers & Schwarz, above n.63, 139.

consent doctrine on the one hand, by failing to provide an alternative legal principle for the imposition of this novel duty on the other, the High Court has created an epistemological conundrum.<sup>79</sup> Milstein, however, is more dismissive and acknowledges that there is no doctrine of informed consent in Australia but chooses to adopt it as 'convenient shorthand'.<sup>80</sup>

It is clear there is some debate regarding the existence (and role) of informed consent in Australian law but a common theme emerges from the literature. Despite the rejection of the term informed consent by the High Court in *Rogers v Whitaker*, as a phrase it continues to have currency and the very decision which rejected informed consent has come to represent it. Perhaps this is simply a case of 'convenient shorthand'. But it is a shorthand that has undermined the rights that the Court was trying to protect. The focus becomes centred on the notion of consent, which in turn is interpreted as being the making of a decision whether or not to proceed with treatment, and as argued by McLean, 'just making a decision is not necessarily an exercise of autonomy.'<sup>81</sup> to truly 'exercise autonomy' a patient must be actively involved in the decision-making process and one way to ensure this is by the provision of relevant (or 'material') information. It is this process that the High Court was focussing on in the *Rogers* decision and therefore the rejection of the notion of informed consent was clear and reasoned. To adopt it in the face of this rejection is to allow the discussion to become distorted and the focus to be on the 'consent' as opposed to the 'informed' component of the discussion.

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<sup>79</sup> D. Mendelson, „Liability for Negligent Failure to Disclose Medical Risk“ (2001) *Journal of Law and Medicine* 358, 362. She does not, however, offer a solution to this „conundrum.“

<sup>80</sup> B. Milstein, „Causation in Medical Negligence – Recent Developments“ (1997) 6 *Australian Health Law Bulletin* 21, 21 and 22. This is perhaps no more than open acknowledgment of the approach adopted by other scholars.

<sup>81</sup> S. McLean, *Autonomy, Consent and the Law* (Routledge-Cavendish, London, 2010), 61.

## The practical application of *Rogers v Whitaker*

### *Informed consent by another name*

[4.100] It is fair to say therefore that despite the measured statements of the High Court aimed at limiting the scope of *Rogers v Whitaker*, it has been given a broad interpretation and application. We have seen that the majority judgment in *Rogers v Whitaker* entails a clear rejection of informed consent and declines to extend the materiality test beyond the provision of advice. Yet subsequent scholarly discussions and judicial interpretations have given the test a broad application and consistently refer to the doctrine of informed consent in Australia. There is, therefore, a crucial difference between the basic principles as stated in the decision and how those principles have been applied. The question we now need to answer is what are the practical realities of this decision and do we have a truly patient-centred test?

When considering *Rogers v Whitaker* and the materiality test, it is easy to focus on the purported patient-centred approach and overlook one key aspect of the decision: the emphasis placed on the relevance of professional opinion. It is this key aspect that leads scholars such as Miola<sup>82</sup> (and indeed, myself) to argue that *Rogers v Whitaker* and *Bolam/Sidaway* are ‘more similar than different.’<sup>83</sup>

The authority of *Rogers v Whitaker* has, as noted above, been clearly endorsed by the High Court in both *Chappel v Hart*<sup>84</sup> and *Rosenberg v Percival*<sup>85</sup> with both decisions focussing on the nature of material information and the needs of respective patients. To understand the true

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<sup>82</sup> Miola, above n.9.

<sup>83</sup> *Ibid.*, 99. I also add *Canterbury* here, which as we will see in the process of application of the test to Sally’s situation, takes her to the same destination as the tests in both the UK and Australia.

<sup>84</sup> (1998) 195 CLR 232.

<sup>85</sup> (2001) 205 CLR 434.

import of these decisions it is important to note the clear statement in *Rosenberg* that *Rogers v Whitaker* did not reject the relevance of professional opinion; rather it 'denied its conclusiveness.'<sup>86</sup> The clear recognition of the relevance of professional practice means that the Australian test, like that in the United States, has evolved into one that can be described as hybrid. There is, however, one significant distinction in that *Rogers v Whitaker*, *Rosenberg v Percival* and *Chappel v Hart* all employ the language of a patient-centred test but then pay heed to the evidence of practitioners. By contrast, the United States test begins with the language of professional practice and then moves to patient-centred consideration.<sup>87</sup> But they both arrive at the same place.

The decision of *Rogers v Whitaker* was indeed a turning point in medical jurisprudence in Australia which, as we have seen in the preceding discussion, provoked widespread interest, concern and, in some circumstances, condemnation.<sup>88</sup> There was concern that it focussed too much on the patient and placed onerous and unrealistic requirements on physicians,<sup>89</sup> that there was likely to be an ongoing effect resulting in an increase in litigation,<sup>90</sup> and the 'remarkable amount of ink and angst' expended by sectors of the medical community drew comment.<sup>91</sup> In reality, however, there has been little change to the test for standard of care. It is a straightforward test which addresses the concept of material risks and has proven to be relatively simple in its application. It must be remembered that in *Rogers v Whitaker*, causation was not at issue. It was readily accepted

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<sup>86</sup> Ibid, 439 (Gleeson CJ). A similar approach can be found in the lower Courts, refer for example to *Hammond v Heath* [2010] WASCA 6, Jan 2010, [21] where Martin CJ notes that „while evidence of practices adopted within the medical profession will not necessarily be determinative, it is, of course, relevant.“

<sup>87</sup> Refer *Cobbs v Grant* 8 Cal.3d 229, (1972) discussed in Chapter 2, under the heading The practical application of *Canterbury* and the emergence of a hybrid test (at [2.70]).

<sup>88</sup> For an excellent summary of the arguments against *Rogers v Whitaker* refer the judgment of Kirby J in *Rosenberg v Percival* (2001) 205 CLR 434 at 478ff.

<sup>89</sup> R. Smallwood „The NHMRC Guidelines for medical practitioners on giving information to patients: 10 years on“ Paper presented at the AIHLE Conference: Informed Consent in Australia - Tenth Anniversary of *Rogers v Whitaker* held at ANU 26 October 2002, 5.

<sup>90</sup> D. Newnes and G. Pynt „Failure of Surgeon to Advise Patient of Risk of Sympathetic Ophthalmia“ (1993) Int I.L.R. 81-83 and F.A. Trindade „Disclosure of Risks in Proposed Medical Treatment“ (1993) 109 LQR 352.

<sup>91</sup> I. Freckelton 'Rogers v Whitaker Reconsidered' (2001) 9 JLM 5, 6.



that Mrs Whitaker would not have proceeded with the treatment had she been aware of the risk of sympathetic ophthalmia. The test of materiality is an easy one to meet. It is the subjective test of causation which has developed into a more formidable hurdle.

Perhaps a key to the difficulty with causation can be found in the true nature of the harm suffered when a patient is not adequately informed. The High Court took care to distance itself from issues of consent, preferring instead to infuse patient choice with meaning.<sup>92</sup> Physical considerations and harms are specifically aligned with trespass and consent. As we will see, the causation enquiry moves away from choice and embraces notions of consent to treatment. I will argue in Part II that it is this crucial shift that undermines judicial protection of the patient's right to material information.

### **Re-visiting the core issues**

[4.110] Turning now to our three main questions we will see that in Australia, the answers are all straightforward. The High Court in *Rogers v Whitaker* set out clear guidelines for judicial consideration of pre-treatment advice and these have been adopted, without challenge, in subsequent High Court decisions and of course, in lower State Courts. The issue in Australia is that despite the rejection of informed consent and autonomy by the *Rogers* Court, both concepts continue to play a central role in judicial and scholarly accounts of the law and this perhaps shifts the focus of the decision away from the original intent of the Court.

#### ***Is 'informed consent' truly about consent?***

[4.120] Of the three jurisdictions under consideration, the Australian High Court represents the clearest and most emphatic rejection of notions of

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<sup>92</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 490 Mason CJ, Brennan, Dawson, Toohey and McHugh JJ.

informed consent. The Court directed us away from informed consent<sup>93</sup> towards choice. In its unambiguous rejection of consent, the Court clearly stated that trespass and validity of consent 'had no place in this decision'<sup>94</sup> which was focussing on the question of the scope and content of the duty to provide pre-treatment advice.<sup>95</sup> We see once again that decisions focussing on the issue of what a patient ought to be told are not about consent and that the answer to this particular question is found in trespass decisions, which are outside of the scope of this discussion.

*Who takes the central role (the prudent patient or the prudent professional)?*

[4.130] The High Court shifted the focus of its enquiry away from professional practice and directed it at the patient at the centre of the enquiry. The correct question to be asked, according to the High Court in *Rogers v Whitaker*, is what would the particular patient deem 'significant' and the label given to this is, of course, materiality.<sup>96</sup> The answer to the question of who takes the central role is therefore straightforward. The *Rogers* Court placed the prudent patient at the centre of its enquiry and it was this shift and rejection of the *Bolam/Sidaway* professional practice test that has been interpreted as the most noteworthy aspect of the decision.

*Are we dealing with patient autonomy or professional standard of care? (Or is it about the doctor or the patient?)*

[4.140] As we have seen, the Australian High Court specifically resiled from notions of autonomy and self-determination, yet the decision has, in the eyes of scholars and the judiciary, come to stand for the protection of patient autonomy. The test, as formulated in *Rogers v Whitaker*, is clearly one of

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<sup>93</sup> Ibid, 490.

<sup>94</sup> Ibid.

<sup>95</sup> Ibid, 483.

<sup>96</sup> Ibid, 490.

professional standard with the Court focussing on the requisite standard of care. Here though, unlike the United States and the United Kingdom, the enquiry begins with the individual patient and asks what is material to them. But it is not all about the patient and considerations of professional practice continue to be relevant. As noted by the *Rosenberg* Court, the High Court did not reject the relevance of professional opinion, rather it 'denied its conclusiveness.'<sup>97</sup>

Thus there is a mixed focus in the judicial consideration of pre-treatment advice. The simplest answer to this question can, however, be found in the words of the *Rogers* Court when discussing the nature of legal issue they were addressing. The Court clearly stated that, in this instance, they were concerned with the provision of negligent advice, which turned on the 'scope and content of duty.'<sup>98</sup> According to the High Court, in the authoritative decision of *Rogers v Whitaker*, we are dealing with an issue of professional standard of care. This standard can, and does, include considerations of the individual patient, tempered by considerations of professional opinion. Thus the enquiry begins with the patient and then shifts to the doctor.

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<sup>97</sup> Ibid, 439 (Gleeson CJ). A similar approach can be found in the lower Courts, refer for example to *Hammond v Heath* [2010] WASCA 6, Jan 2010, [21] where Martin CJ notes that „while evidence of practices adopted within the medical profession will not necessarily be determinative, it is, of course, relevant.“

<sup>98</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 483 (Mason CJ, Brennan, Dawson, Toohey and McHugh).

## Chapter 5: Bringing it all Together

### The more things change, the more they stay the same

[5.10] In the preceding Chapters we have been evaluating the relevance of the term ‘informed consent’ and have seen that it is by no means a concept embraced by the Australian judiciary. However, as pointed out by Kirby J in *Rosenberg v Percival* the rejection of the term amounts to little more than linguistic niceties. The underlying issues remain the same. ‘Materiality’ and choice in Australia are much the same as materiality and informed consent in the United States.<sup>1</sup> Despite the ongoing debate regarding the appropriate test, particularly evident in the United Kingdom where the professional practice test, as enunciated in *Bolam*, sits uncomfortably with some members of the judiciary,<sup>2</sup> this is not the truly problematic aspect of the law. I suggest that the ongoing discomfort with the test for standard of care and struggle to identify a more appropriate one, is symptomatic of the struggle to fit the protection of one right within a framework initially created in the context of another, quite separate right. The right to information is quite separate and distinct from the right to bodily integrity and the doctrine of ‘informed consent’ fails to recognise this.

In all three jurisdictions under consideration, it is accepted that the foundational premise of the ‘doctrine of informed consent’ (or whatever other label is utilised) is the unchallenged right of the patient to receive sufficient information. Of course this then opens the question of what constitutes sufficient information and this is where the issue of the nature of the duty usually arises. The best way to answer this question would be to focus on the right under consideration and the individual being protected. The enquiry

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<sup>1</sup> See His Honour’s comments in *Rosenberg v Percival* (2001) 205 CLR 434, 476 and discussed in Chapter 4 under the heading Interpretations of *Rogers v Whitaker* (at [4.30]ff).

<sup>2</sup> This debate is detailed in Chapter 3 and is evidenced in Australia with the clear rejection of the *Bolam* test as inappropriate.

most logically would begin and end with the patient. However, as we have seen in the preceding discussions, this is not the way that the law currently deals with problems of pre-treatment advice. The judicial focus remains on the nature of the duty of care expected of the doctor in the provision of information.

The problem with this approach is not readily apparent if one begins from a recognition of the correlative nature of the relationship between rights and duties. The right to information cannot exist (or be measured) without reference to the duty to provide it. Hohfeld reduced the law to 'eight jural conceptions,'<sup>3</sup> and employed the words of an American Judge to explain the specific relationship between a right and a duty: 'A duty or a legal obligation is that which one ought or not to do. 'Duty' and 'right' are correlative terms when a right is invaded, a duty is violated.'<sup>4</sup>

The nature of rights and duties is not challenged here. What is challenged is the judicial practice in the pre-treatment advice cases of protecting the right to information solely through a consideration of the duty to provide it. In practice, the application of the tests as they currently stand means that the focus of the discussion remains on the test for standard of care. The nature of the right to information does not play an overt role in the judicial process beyond an initial nodding acquaintance with the rationale of autonomy (or self-determination). In short, the test, as it stands, 'concentrates on descriptions of duties rather than rights.'<sup>5</sup>

The issue with which this thesis is concerned is one of inappropriate emphasis and the adoption of the unrelated language of consent. As a result of this choice of language, the right to information (which I will describe as a dignitary right that is concerned with one's personal dignity and unrelated to

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<sup>3</sup> W.N. Hohfeld, *Fundamental Legal Conceptions* (Yale university Press, Newhaven, 1964), 38.

<sup>4</sup> Ibid, citing *Lake Shore & M.S.R. Co v Kurtz* (1984) 10 Ind App, 60.

<sup>5</sup> S.A.M. McLean, *A patient's right to know: Information disclosure, the doctor and the law* (Dartmouth Publishing Company, Aldershot, 1989), 80.

the external or physical aspects of being) is linked to the trespassory notion of consent and, ultimately, measured by the logically irrelevant physical harm. A similar problem arises in the context of causation when we see that the loss of decision-making power is measured by an unrelated physical harm. We will discuss this in more detail in Part II. For now, it is sufficient to note the disparity between the underlying motivations of the doctrine of 'informed consent'<sup>6</sup> and its application in practice.

If we are serious about protecting the right of a patient to a meaningful pre-treatment discussion that includes all material information, then the pre-occupation with the nature of the test for standard of care needs to be put to one side. This suggestion clearly runs counter to the flow of judicial opinion which has placed emphasis on the significance of the rejection or acceptance of one model or the other. However, a close consideration of the different tests as they have evolved across the jurisdictions reveals that however fine these distinctions are, they have little practical import. I will support this assertion through a brief comparative discussion of the three 'different' tests, followed by an application of each test to Sally's position. We will see that whichever way we look at it, Sally's doctor was in breach of his duty to provide appropriate pre-treatment advice.

Turning first to the United States and Australia, it is illustrative to begin by considering *Canterbury*.<sup>7</sup> The *Canterbury* Court, like that in *Rogers*,<sup>8</sup> specifically noted the need to look beyond proficiency in diagnosis and treatment when determining the scope of a physician's duty of care with the duty being founded on more than simply the provision of treatment.<sup>9</sup> As outlined in Chapter 2, the emphasis in the judgment was upon the personal

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<sup>6</sup> Once again, I would like to reiterate that I will, somewhat reluctantly, use the term informed consent in early discussions as it readily identifies the legal framework under discussion and therefore simplifies the argument. The latter parts of the thesis will however, see a complete rejection of the term and the substitution of the more appropriate „informed choice.“

<sup>7</sup> *Canterbury v Spence* 464 F.2d 772, (1972).

<sup>8</sup> *Rogers v Whitaker* (1992) 175 CLR 479.

<sup>9</sup> *Canterbury v Spence* 464 F.2d 772, (1972), 781 (Robinson J).

prerogative of the patient (as opposed to the physician) to determine for himself the direction in which his interests seem to lie.<sup>10</sup> The key issue was how the patient is to determine how these 'best interests' can be served, a similar debate to that in *Rogers*.

What then is the appropriate standard? The Court specifically rejected the full disclosure standard describing it as prohibitive and based upon an unrealistic expectation that physicians discuss with their patients every risk of proposed treatment no matter how small or remote.<sup>11</sup> The emphasis was on the reality that the right to make a decision can only be effectively exercised if the patient possesses enough information to enable an intelligent choice.<sup>12</sup> Sufficient information is determined by establishing what information is 'material to the decision' with the law determining what the appropriate standard will be.<sup>13</sup>

When the practical application of both *Rogers v Whitaker* and *Canterbury* are placed side by side, the similarities are inescapable. In both decisions, it is the responsibility of the Court, not the medical profession, to determine the appropriate level of information to disclose to the patient. In doing this, the Court is to consider the nature of the relationship between the doctor and the patient, the level of knowledge of the patient, their individual concerns and what will be material to that patient. In *Canterbury* the patient is to have sufficient information to make an intelligent choice; in *Rogers v Whitaker* sufficient information to make a meaningful choice is required. Yet *Canterbury* purports to endorse informed consent and *Rogers v Whitaker* to reject it. Autonomy and self-determination apparently play a significant role in *Canterbury*, yet in *Rogers v Whitaker* they are deemed to be unhelpful terms. Despite this apparent difference in reasoning and application the underlying

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<sup>10</sup> Ibid.

<sup>11</sup> Ibid, 786.

<sup>12</sup> Also note that *Rogers v Whitaker* also emphasised the notion of material risk so as to enable the patient to make a meaningful choice (*Rogers v Whitaker* (1992) 175 CLR 479, 490).

<sup>13</sup> Ibid, 786-7.

law appears to be the same. In the United States there is informed consent. In Australia there is, according to the High Court, informed choice, which according to later interpretations, is essentially informed consent.<sup>14</sup> We therefore have some linguistic differences to which much judicial and scholarly discussion has been devoted, but I suggest that the practical application is the same.

Turning then to the United Kingdom we see a test which certainly appears to stand alone. The enquiry begins with the patient but quickly moves to the profession and the Courts have endorsed a standard determined by the profession. The key point of distinction from *Rogers v Whitaker* and *Canterbury* is the description of the provision of advice as a matter of clinical judgment.<sup>15</sup> This position has been clearly rejected by the Courts in both the United States and Australia on the basis that the authority to determine what is appropriate in any given set of circumstances before the Court rests with the Court, not with the very profession under consideration. In the United Kingdom, the Courts retain one discretionary right as introduced in *Bolitho*<sup>16</sup> and that is the ability to reject the professional opinion if the Court is of the view that it lacks a logical basis.<sup>17</sup> Whilst this may appear to retain authority in the Court through the provision of a veto-like power, it is difficult to imagine a situation in which an accepted body of healthcare professionals could ascribe to a practice that the Court is willing to describe as lacking a logical basis.

In the absence of specific or individual evidence regarding professional standards we can find guidance in the General Medical Council (GMC) Consent Guidelines.<sup>18</sup> These Guidelines avoid all reference to informed

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<sup>14</sup> Refer for example, the discussion of Kirby J in *Rosenberg v Percival* (2001) 205 CLR 434, 476.

<sup>15</sup> *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1984] QB 493, refer discussion above p.72ff.

<sup>16</sup> *Bolitho v City and Hackney Health Authority Respondents* [1998] AC 232.

<sup>17</sup> *Ibid*, 241.

<sup>18</sup> General Medical Council, *Consent: patients and doctors making decisions together (Guidance for doctors)*, <<http://www.gmc-uk.org/guidance/125.asp>> at 20 January 2011.



consent and emphasise the nature of the doctor/patient relationship as a joint one: with all decisions made together. With respect to the level of information expected, it is stipulated that the doctor must give patients the information they 'want or need' about, *inter alia*: diagnosis and prognosis, uncertainties and options (including the option not to treat) and potential benefits, risks and burdens along with the likelihood of success.<sup>19</sup> Importantly for present purposes the Guidelines stipulate that no-one but the patient can make a decision regarding treatment<sup>20</sup> and emphasise the individual nature of the pre-treatment discussions which have the key aim of providing 'clear, accurate information ... presented in such a way patients can understand, can help them make an informed decision.'<sup>21</sup> If these are the professional standards to be applied in the context of pre-treatment advice, they are not dissimilar to the considerations endorsed in both Australia and the United States. We see once again a standard of care which has been the subject of much intense debate but has not diverged too much from other, purportedly more patient-centric tests. This position will be clearly demonstrated through applying all three tests to Sally.

## **Sally**

[5.20] The best way to explain my point here is through the use of a practical example. This is where the story of Sally becomes relevant. Sally is 20 years of age and has been diagnosed with a degenerative eye disease which, if left untreated, will deteriorate and with certainty, she will be completely blind within 5 years. The doctor tells Sally of a particular treatment that is available. This treatment, at best, will slow down the degeneration of her sight and she could be able to see for up to 10 years. The surgery itself will not effect a complete cure, but it does carry a risk of immediate onset of blindness. This is extremely unlikely, let us say there is a 1 in 14,000 chance of

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<sup>19</sup> Ibid, para 9.

<sup>20</sup> Ibid, para 13.

<sup>21</sup> Ibid, para 28.

the risk manifesting (much the same as with Mrs Whitaker). However the doctor has had a relationship with Sally for as long as she can remember. Indeed, he is the family doctor and has been treating her in one way or another since conception. He feels protective towards her and is confident that the procedure will go well. He chooses not to tell her of this small (and to him) inconsequential risk. Sally, under the mistaken belief that her doctor can effect a complete cure, agrees to undergo the treatment, the risk manifests and she suffers complete and immediate loss of sight. Understandably Sally is distressed by this outcome and seeks recompense.

If we bring Sally before those American Courts which adhere to the principles of *Canterbury v Spence (Canterbury)*<sup>22</sup> the key question asked by the Court would be what is material to the patient? Or, in other words, what would be 'significant' to their decision?<sup>23</sup> Here Sally is young and perhaps has high expectations of her doctor. She considers that he will be able to effect a cure (as he has done so with all of her other childhood ailments). The reality of her situation is that this will never occur and one would imagine that she would wish to retain her sight as long as possible. It is quite simple to conclude that she would view the fact that she will inevitably lose her sight and that there is a chance that she could suffer immediate blindness as 'significant.'

In the interests of completeness, before leaving the United States we must also bring Sally before a Court which adopts a different approach. According to *Cobbs v Grant* we need to ask what information a 'skilled practitioner of good standing would provide under similar circumstances,'<sup>24</sup> with the additional note that there is no need to provide information beyond that expected by the medical fraternity if such information would have meant that the patient is unable to 'dispassionately weigh the risks.'<sup>25</sup> Here one would assume that it is reasonable to expect the medical fraternity to support disclosure of the true

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<sup>22</sup> 464 F.2d 772, (1972).

<sup>23</sup> Ibid, 785-786.

<sup>24</sup> *Cobbs v Grant* 8 Cal.3d 229, (1972), 244-5.

<sup>25</sup> Ibid, 246.

nature of the patient's condition along with a realistic assessment of long-term prognosis. Beyond a desire to protect Sally from the harsh realities of her condition, there is no evidence of a clinical assessment of her inability to process information or make rational decisions. Under *Cobbs v Grant* it is likely that once again, Sally's doctor will be found to have breached his duty of care. A final test from the United States comes to the same conclusion. *Grab v Zoo* referred to the need to provide 'medically significant' information.<sup>26</sup> Clearly it is medically significant that, firstly, Sally will never be 'cured' and, secondly, she could suffer from immediate loss of sight. Once again, breach of duty is easy to establish.

Taking Sally to the United Kingdom would not change the outcome. The Courts there have expended a great deal of energy in the rejection of the *Canterbury* approach, remaining firm on the position that there is no role for a patient-centred test. As we saw in Chapter 3, the test is driven by professional standards and clinical judgments of what is appropriate information. In the absence of evidence of what would be the usual practice in these circumstances it is illustrative to turn to the GMC Guidelines<sup>27</sup> which, as outlined in Chapter 3, clearly set out certain expected standards. These include the provision of information pertaining to diagnosis and prognosis, uncertainties, risks and the likelihood of success.<sup>28</sup> Here the diagnosis is of a degenerative eye disease with a prognosis of certain blindness (at some uncertain time in the future; at best it will be 10 years away). With respect to the uncertainties, the delay of blindness is unknown and there is a risk of immediate onset of blindness. The final issue is that of the likelihood of success and the response here depends upon individual interpretation of success: In the Doctor's eyes success is a delay of up to 10 years; in Sally's eyes success is a complete cure. Her version of success has a 0% chance of occurring. None of these facts were conveyed to Sally and she was able to

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<sup>26</sup> *Gorab v Zook* 943 P.2d 423 (1997), 427.

<sup>27</sup> General Medical Council, *Consent: patients and doctors making decisions together (Guidance for doctors)*, <<http://www.gmc-uk.org/guidance/125.asp>> at 20 January 2011.

<sup>28</sup> *Ibid*, para 9.

maintain her fantasy of 'success.' An application of the GMC Guidelines would therefore have the likely conclusion of breach of duty.

Finally, in Australia the Court would ask one simple, straightforward question: Was the information withheld by the Doctor 'material' to Sally's decision-making process? That is, would she attach significance to it?<sup>29</sup> Clearly the true nature of her condition and the long-term prognosis would in fact be of significance to Sally and ought to have been conveyed to her. Once again, a breach of duty would be established.

We have seen in the preceding Chapters that much scholarly and judicial energy has been expended in the pursuit of the most appropriate test of standard of care. Indeed, this very discussion simply adds to the debate and serves to illustrate the plethora of arguments on each side of the divide. In the judgments, there are careful and fine distinctions drawn between different linguistic terms but as we have seen through the application of the different tests to Sally's situation, the difference lies in terminology and not substance. However his duty is measured, Sally's Doctor failed to meet the requisite standard of care.

There is another important issue that has been highlighted in this discussion. From the very beginning of the 'informed consent' discussion there is a clear flaw: the intent of the doctrine does not match the mechanism employed by the law to determine, in this instance, the requisite duty.<sup>30</sup> The enquiry begins with an individual right to receive information that is relevant and appropriate to the particular patient in a particular set of circumstances. This right is then measured by a determination of the content of a duty of another (the doctor) and the relationship that they have with their profession. The right of the patient is diminished and the duty of the doctor to behave in

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<sup>29</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

<sup>30</sup> As discussed above, I am not denying the relevance of the content of a correlative duty but I suggest that the discussion cannot focus solely on that duty, it must also address the nature of the right, and move to protect that rights.

accordance with professional standards emerges as the predominant consideration. Similarly, when we turn to the question of causation in Part II, we will see that the Courts become mired in the complexities which arise when they are called upon to measure a personal loss of choice by the manifestation of an entirely different form of harm (manifestation of a physical risk). The end result is a mix of tests across (and within) the jurisdictions, each aiming to protect the individual right to information but focussing on questions of professional standards as opposed to what the particular patient wants, or needs, to know. And the end result of all of this analysis and judicial assertion that certain tests are superior to others? The different tests all amount to the same thing. They simply represent different routes to the same conclusion.

## PART II: IN SEARCH OF THE MISSING LINK - CAUSATION

### Introduction

*'The law should eliminate the cause of action for lack of informed consent. Informed consent cause of action does nothing to promote or protect patient autonomy ... many features of the cause of action lead to its lack of utility. The law is forced to go at the entire enquiry backwards. The question the law wants to answer is whether the patient had adequate information to autonomously exercise his will. In other words, what was on the patient's mind? However the law does not ask what was in the patient's mind. Instead it asks what the doctor did. Did the doctor tell the patient enough.*

*It is easy to predict that law that must be done backwards is not going to work out very well.<sup>1</sup>*

Questions regarding patient consent to treatment clearly begin with a consideration of what the doctor did (or did not) do, with patients themselves being left on the periphery of the discussion. The language adopted by the judiciary across all three jurisdictions, is that of consent (or fleetingly in Australia, choice). As we have seen in Part I, the focus of enquiry is on the scope of the duty of care owed by the doctor. As argued by Roger Dworkin, the enquiry is conducted backwards. In all three jurisdictions, the crucial issue is one of professional standards<sup>2</sup> and as demonstrated by the preceding discussion, the measure of those standards has been the subject of much rigorous debate.

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<sup>1</sup> Roger B. Dworkin, „Getting What We Should from Doctors: Rethinking Patient Autonomy and the Doctor-Patient Relationship“ (2003) *Health Matrix* 235, 283.

<sup>2</sup> With the debate centring on how that standard is to be measured.

In every case dealing with pre-treatment advice, there is no question regarding the actual touching of the patient; there is no trespass to the person as the doctor is acting within the licence of the patient. As we are dealing with standards of behaviour, the appropriate cause of action is negligence. The doctor is not intentionally interfering with the patient's bodily integrity but is potentially failing to meet their standard of care in the provision of advice and treatment. Once breach of duty is established, and as we saw in Part I this is not an onerous task, the next stage of the enquiry is causation. It is here that the patient plaintiff most often stumbles in their action.

At the base of the causation enquiry is the fact that the law 'takes no cognisance of carelessness in the abstract'<sup>3</sup> meaning that liability will not be imposed unless the duty and breach can be linked to the loss or damage suffered. The identification of a duty to inform (and a corresponding failure to do so) is only the beginning of the process. A thread of causation must lead from that failure directly to the patient's loss: Did the failure to inform make a material difference to the outcome? My concern with this specific stage of the enquiry is that the Courts seek to link the failure to provide sufficient advice with a logically irrelevant harm.<sup>4</sup> As a result, the causative link is rarely found. In asking the question of whether or not the patient would have consented to the treatment, the Courts divert the enquiry away from the right to information towards the idea of consent and concepts ordinarily aligned with trespass. In focussing on the issue of whether or not the patient would have proceeded with the treatment if they had been informed of this risk, the Courts are, quite simply, asking the wrong question.

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<sup>3</sup> *Donoghue v Stevenson* [1932] AC 562, 619 (Lord McMillan).

<sup>4</sup> I am referring here to the gap between the dignitary harm suffered when the patient received insufficient information and the subsequent manifestation of a physical harm arising out of medical treatment. This was raised in Part I (in particular Chapter 5) and will be explored in depth here in Part II.

Causation is a 'notoriously difficult area of law'<sup>5</sup> and, as pointed out by Honoré, there are 'no uniquely right answers to difficult legal problems' such as this.<sup>6</sup> The Courts in the pre-treatment advice cases have struggled with the traditional approach to causation and have become adroit at leaping the evidentiary gaps,<sup>7</sup> often through the adoption of value-laden language and appeals to notions of what is just and right as they seek to impose liability upon those who ought to be responsible. With Courts retreating behind such language and appealing to poorly-articulated 'policy considerations,' the underlying rationale of negligence (to compensate for a wrong) has been pushed to one side revealing the need for a clear direction in medical consent cases.

A close analysis of causation will demonstrate the problematic nature of an enquiry that relies on finding a link between what I am referring to as a 'dignitary harm'<sup>8</sup> and a subsequent physical loss. This linking of harms of a different type is as useful as measuring the length of a piece of string by its weight: conceptually difficult and practically impossible. There is a failure in logic and this results in a missing causative link. Courts simply cannot find the link between the failure to meet a duty to protect a dignitary interest and the sustaining of an unrelated physical harm.

The significance of causation is emphasised across the three jurisdictions under discussion, but the nature of the test adopted in each jurisdiction differs slightly. At one end of the spectrum is the subjective approach favoured in the United Kingdom; at the other end is the (apparently) completely objective approach adopted by the United States; and somewhere in the middle is Australia, with an overarching subjective approach tempered by objective

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<sup>5</sup> M. Stauch, „Taking the Consequences for Failure to Warn of Medical Risks,“ (2000) 63 *The Modern Law Review* 261, 268.

<sup>6</sup> A. Honoré, „Medical Non-Disclosure, Causation and risk: *Chappel v Hart*“ (1999) 7 *Torts Law Journal* 1, 3

<sup>7</sup> The term leaping evidentiary gaps is borrowed from Jane Stapleton's excellent examination of the problematic nature of the medical consent cases, „Lords A“Leaping Evidentiary Gaps“ (2002) 10 *Torts Law Journal* 276.

<sup>8</sup> That is a harm to one's personal dignity through a limitation of choice. See definition provided above, Chapter 5, The more things change, the more they stay the same (at [5.10]).



considerations.<sup>9</sup> And yet a close examination of the three jurisdictions reveals that in developing divergent causation tests they have, in an apparently contradictory manner, drawn closer together.

The jurisdiction commonly identified as the most patient friendly at the duty stage is the United States. Yet it is here that we see the individual patient most firmly removed from consideration at the causation stage. The test developed in the United States is an objective one that turns on questions of the 'reasonable' patient. In Australia, where the doctor-centric *Bolam* test was rejected in favour of the patient-centred materiality test, the trend ostensibly continues with the development of a subjective causation test. We will see, however, that careful examination of key decisions reveals that individual Australian plaintiffs have generally been treated in the same manner as their American counterparts, with plaintiff evidence of what they would have done being treated with open scepticism and, at times, rejected outright.<sup>10</sup> In the United Kingdom, where *Bolam* defers to the expertise of the health providers in establishing duty, the House of Lords has rejected traditional causation tests in this context preferring instead to consider questions of 'justice.'<sup>11</sup>

In each of the three jurisdictions, therefore, there appears to be a change of direction once enquiry moves from duty and breach to causation. Where duty was based upon professional standards, causation becomes patient-focussed. Conversely, in the jurisdiction where the patient firmly occupied a central position at the duty stage (the United States), they recede into the background of causation. The result is that across all three jurisdictions, patients and physicians are accorded similar significance and a balance is struck between patient and professional considerations. And in all

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<sup>9</sup> In Australia the question begins from what would the plaintiff have done if told of the risk and the evidence is tested against what the „reasonable“ patient in that position would have done. It must be recognised that this approach has won some support in the United Kingdom, refer *Smith v Barking, Havering & Brentwood Health Authority* [1994] 5 Med L.R. 285.

<sup>10</sup> *Rosenberg v Percival* (2001) 205 CLR 434. To be discussed in more detail below.

<sup>11</sup> *Chester v Afshar* [2005] 1 AC 134. This is complicated further by the merging of the stages of enquiry through the introduction of language such as „giving content to the duty“ and we will be considering this in more detail below.

jurisdictions, the Courts struggle to find a link between the lack of information and the manifestation of a physical harm.

Part II of this thesis will focus on the vexed question of causation. The three questions to be answered in this part of our discussion are:

1. What is the test for causation (is it subjective or objective)?
2. What factors influenced the development of the test in each jurisdiction? and
3. What (if anything) is the problem with the chosen approach?

In addressing these questions I will, as in Part I, carefully analyse the different approaches to this stage of the enquiry. Discussion will begin with the most patient-centred approach which, in this instance, is represented by the subjective test of the United Kingdom, then move through Australia (a hybrid approach) and conclude with the United States (an emphatically objective test). I will identify the apparent point of distinction between the jurisdictions as the nature of the test but, once again, I will argue that this is an empty debate as the outcome of all of the tests is the same.<sup>12</sup> Here, as with the duty and breach enquiry, Courts in the three different jurisdictions choose different paths to reach the same destination (mainly because they are using the incorrect guide-book and asking the wrong questions). I will conclude once again with Sally and an application of each of the tests to her situation.

From this discussion, as with Part I, certain themes will emerge. Of significance here is the role of policy in 'leaping evidentiary gaps'<sup>13</sup>: this will be considered in some detail in Chapter 9. And once again questions of autonomy and choice will be raised and these issues will form the substance

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<sup>12</sup> An exception here is the decision of *Chester v Afshar* [2005] 1 AC 134. In this decision, the Court created a link between the breach of duty and the physical harm but this was only possible through a „modest departure „ (Lord Steyn, [24]) and „some extension of“ (Lord Walker, [101]) existing principle.

<sup>13</sup> J. Stapleton, „Lords A'Leaping Evidentiary Gaps“ (2002) 10 *Torts Law Journal* 276.

of the discussion in Part III and will facilitate the proposed shift away from 'informed consent' towards 'informed choice.'

## Chapter 6: The United Kingdom

### Introduction

[6.10] Analysis of the decisions in the United Kingdom reveals an ongoing struggle to reconcile the rationale underlying the imposition of a duty of care and traditional causative principles. Once breach has been established (through the application of the *Bolam* professional standards test) the Courts then move on to identifying a link between that breach and the harm suffered. In the pre-treatment advice (or consent) cases the legally cognisable harm has been identified as the manifestation of a risk inherent in the medical treatment and the Courts must identify a clear link between this harm and the breach of duty to advise the patient. It is at this point in the enquiry that the Courts in the United Kingdom struggle. In attempting to bridge the gap between the breach of a duty to provide information and the underlying personal loss of a right to information, the Courts begin to raise questions of who *ought* to be responsible as opposed to who *is* responsible. The result is a judicial appeal to justice and a setting aside of the more traditional causative principles.

As we progress through the analysis of the flawed judicial process in the United Kingdom (and in following Chapters, the United States and Australia) it is important to return to the core question: Would this be necessary if the doctrine were informed choice instead of informed consent? The ongoing search for the missing causative link is only necessary because the focus continues to be on the issue of consent which, as we have already discussed, is relevant to trespass but not to negligence. This argument will be pursued further below, but for now it is important to review the current approach and clearly demonstrate where (and how) it is flawed.

## Appeals to justice

[6.20] The duty stage of the negligence enquiry is concerned with the identification of the need to moderate behaviour through considerations of its impact on others and, of course, what is the appropriate measure of that moderation.<sup>1</sup> It would seem logical at this point to include questions of what *ought* to be expected in the circumstances. The Courts in the United Kingdom have, as we saw in Chapter 3, chosen not to take that path, preferring instead to rely on measures of professionalism as established by a 'responsible body of peers.'<sup>2</sup> There is little reference to the individual patient and what *ought* (in the sense of what is morally appropriate) to be done. This changes at the causation stage of the enquiry which has been described as 'an attribution of responsibility'<sup>3</sup> requiring the Court to scrutinise closely the underlying rationale of the relevant duty, in an attempt to determine not only who is responsible for the loss sustained, but also who *ought* to be responsible. As Jones<sup>4</sup> points out, the Courts have taken care to avoid 'emptying the duty of content,'<sup>5</sup> preferring instead to make a 'value judgment on responsibility'<sup>6</sup> with the view that there is no 'uniform causal requirement for liability in tort ... it depends upon the basis and purpose of the liability.'<sup>7</sup> This then conflates the duty and causation stages of the enquiry and imports value-based evaluations into questions of 'did this lead to that.' I suggest that the reason for this muddying of the causation enquiry is, quite simply, because it is the incorrect 'that' (outcome or loss) that is at the heart of the enquiry.

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<sup>1</sup> As explained in Part I, the dispute was between patient needs and professional practice as a means of measuring standard of care.

<sup>2</sup> *Bolam v Friern Hospital Management Committee (Bolam)* [1957] 1 WLR 582, 587.

<sup>3</sup> M.A. Jones, „But For” Causation in Actions for Non-Disclosure of Risk,” (2002) 18 *Tolley's Journal of Professional Negligence* 192, 192.

<sup>4</sup> *Ibid.*, pp192-195.

<sup>5</sup> *McGhee v National Coal Board* [1973] 1 WLR 1, [47]. This and the following 3 decisions are explored in detail by Jones, above n.3 and are included here to provide insight into the approach of Courts to questions of causation.

<sup>6</sup> *Kuwait Airways Corp v Iraq Airways Co* [2002] 3 All ER 209, [74] (Lord Nicholls).

<sup>7</sup> *Ibid.*, [127] and [128] (Lord Hoffman).

To import notions of what ought to happen (as opposed to what actually did happen) at this pivotal stage of the enquiry has led to a lack of clarity and certainty. The line between duty and causation has become blurred. The duty to warn, which was formerly determined purely on an objective standard imposed by a professional body, becomes a value laden notion pertaining to the nature of 'justice.'

The legal test for standard of care was well established in *Bolam*<sup>8</sup> and, as outlined in Chapter 3, the Courts have declined to retreat from the position adopted in that decision. The professional standard test represents clearly enunciated law and provides a transparent and consistent legal framework. Once duty and breach have been established however, the decisions have proven to be less clear. Particularly troublesome have been the cases where there is no clear evidence that the failure to warn a patient of a risk made any difference to their actions. The problem facing the Courts in these situations is that, whilst it is clear that a right has been violated and a loss sustained, the insistence of linking the intangible loss of a right with the tangible, but perhaps unrelated, physical harm means that under traditional causative principles, no-one will be held accountable. In situations where this problem arises, we see the Courts rationalising their decisions by referring to specific characteristics of the plaintiff and the nature of the duty to inform.<sup>9</sup>

As we shall see when we consider the decision in *Chester v Afshar*, it was unacceptable to the House of Lords that a deserving plaintiff be denied recompense on the grounds of established legal principles. In search of

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<sup>8</sup> *Bolam v Friern Hospital Management Committee (Bolam)* [1957] 1 WLR 582.

<sup>9</sup> See for example, *Chester v Afshar* [2005] 1 AC 134 which relied upon the rationale behind the duty to inform to conclude that the patient „ought“ to recover (Lord Hope) and the characterisation of the plaintiff as „honest and innocent“ (Lord Walker, [101]).

justice then, the Law Lords ‘fearlessly embraced ... policy.’<sup>10</sup> This retreat into ‘policy’ has been explained on the grounds of lending meaning to the apparent rationale of duty to inform<sup>11</sup> but in reality it served to expose some flawed reasoning. The crux of the problem lies in the belated entrance of the autonomous patient – a character largely absent from the duty discussion but suddenly central to the determination of causation.<sup>12</sup> In complete contradiction to the underlying essence of negligence law<sup>13</sup> the actual damage suffered (or not) becomes irrelevant, the Court focusing instead on the nature of the ‘violated’ right.<sup>14</sup> Such a focus would have been entirely appropriate when determining the nature of the duty: However, causation should be about loss or damage and liability.<sup>15</sup>

It is important to explain why this is of concern, especially as the crux of my argument is that the ‘dignitary’ harm of denial of choice ought to be recognised. The problem with the approach adopted in *Chester*<sup>16</sup> is not that the outcome is incorrect; it is that the path taken to get to that outcome is wrong. It is artificial and does not accord with established legal principle (but claims to). The current model of loss is one of physical harm with the Court searching for a link between the failure to provide appropriate pre-treatment advice and the later manifestation of an inherent risk. The discussion begins with the personal right to choose

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<sup>10</sup> D. Brahams, „Public Policy – House of Lords Increases Scope for Claimants to Recover Damages for Negligent Failure to Warn of Treatment Risks,” (2004) 72 *Medico-Legal Journal* 113,114. The Law Lords describe their approach as one of policy, therefore this term will be used here. Analysis of the decisions will reveal however that it is a „policy” based upon individual perceptions of what the most appropriate outcome would be. The role of „policy” will be more closely analysed in Chapter 19.

<sup>11</sup> S. Maskrey and W. Edis, „*Chester v Afshar* and *Gregg v Scott*: Mixed Messages for Lawyers,” (2005) 3 *Journal of Personal Injury Law* 205, 209.

<sup>12</sup> *Chester v Afshar* [2005] 1 AC 134. All of the Law Lords emphasised the significance of the autonomous patient, Lord Bingham (in dissent) [5], Lord Hoffman (in dissent) [28], Lord Steyn [14] and [24], Lord Hope [56] and Lord Walker [92].

<sup>13</sup> As Lord Bingham stated in *Chester v Afshar* [2005] 1 AC 134, [9] „it is trite law that damage is the gist of the action in negligence.”

<sup>14</sup> The concept of a violated right is central to the reasoning in *Chester v Afshar* [2005] 1 AC 134, and will be considered in detail below.

<sup>15</sup> Although questions of „morality” and culpability have been viewed as an integral component of the broader causation question, they should not be determinative, P. Cane, *Responsibility in Law and Morality*, (Hart Publishing, Oxford, 2002), Chapter 4.

<sup>16</sup> To be outlined in more detail below.

between all reasonable options and then shifts to the professional duty of the doctor and the outcome of the surgery. The true nature of the harm is not recognised by the current approach and as a result, the Courts struggle and application of the law becomes inconsistent. Until the true nature of the harm is identified and embraced by the law, such inconsistencies will continue and the interest at the heart of the doctrine will be denied. This point will be demonstrated through a close analysis of the case law.

### **The case law**

[6.30] The current position in the United Kingdom is best illustrated by a consideration of the evolution of causation through a series of cases. The discussion will begin with three decisions<sup>17</sup> which all adopt the traditional approach to causation. In each of these decisions, the Court considered all of the relevant factors and determined whether, on the balance of probabilities, the patient would have proceeded with the treatment if warned of the relevant risks.

The approach changed with the difficult case of *Chester*<sup>18</sup> in which the focus shifted to the right of a patient to refuse treatment<sup>19</sup> resulting in compensation for the infringement of a right to autonomy<sup>20</sup> as opposed to exposure to risk. The perceived aim of the duty (which, historically, has not been embraced by the judiciary in the United Kingdom at the duty stage of the enquiry), was given a primary role in *Chester* with this, rather than well-established negligence principles, driving the outcome.

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<sup>17</sup> *Smith v Salford Health Authority* 5 Med L.R. 321, *Smith v Barking, Havering & Brentwood HA* [1994] 5 Med L.R. 285, *Pearce v United Bristol Healthcare NHS Trust* [1999] ECC 167. Although it is worth noting that *Pearce* did not turn on causation and the comments, made as *obiter* tend towards a more paternalistic approach.

<sup>18</sup> *Chester v Afshar* [2005] 1 AC 134. Difficult because there was no clear conclusion as to what the patient would have done if she had been warned of the risk, indeed the Court openly accepted the submission that Mr Afshar's failure to inform did not materially alter the chance of the risk manifesting.

<sup>19</sup> Maskrey and Edis, above n. 11, 209.

<sup>20</sup> *Ibid*, 215.



The question is, why did the House of Lords move away from the sound and reasoned process demonstrated in the earlier cases and embrace a 'policy' based upon individual views of what is just and right? Whilst I would argue that the shift in focus is appropriate, it is problematic in this context because the causative link is manufactured. A broader and more consistent acceptance of the nature of the loss as a dignitary harm (denial of choice) would enable the creation of a clear legal framework and an appropriate and consistent analysis of cases involving pre-treatment advice. As the model currently exists, Courts such as the *Chester* Court, instinctively recognise the true nature of the harm suffered but struggle to openly address that harm within the existing framework. The problem lies in the focus on the mainly unrelated harm and the absence of a clear or logical link. The result then, as we will see in *Chester*, is the judicial creation of a link (instead of the more appropriate judicial identification of a link) and an undermining of the integrity of the law.

*Smith v Salford Health Authority*<sup>21</sup>

[6.40] The plaintiff in this instance was a previously active man who suffered complications following spinal fusion surgery. There was some dispute regarding the content of his discussion with the surgeon but it was accepted that whilst the plaintiff was told of the risks of not having the surgery, those risks inherent in proceeding with the treatment were completely overlooked. The conversation took place in an examination room following tests when the plaintiff was in a vulnerable state and the judge found that the treating surgeon did not offer the plaintiff any practical alternative or pursue the possibility of conservative treatment.<sup>22</sup>

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<sup>21</sup> [1994] 5 Med L.R. 321.

<sup>22</sup> *Ibid*, 329-330 (Potter J).

Across all of the three jurisdictions under discussion, when causation becomes an issue, the judges tend towards commentary on the nature of the evidence given by both the plaintiff and the defendant and are clearly swayed by personal characteristics and consistency of evidence. In this instance, for example, Potter J made scathing comments about Mr Cowie (the treating surgeon) noting that the shifts in emphasis of his evidence led to the conclusion in favour of the plaintiff's version of events.<sup>23</sup> Despite his clear rejection of the defendant as credible and acceptance of the plaintiff as honest, His Honour went on to reject the plaintiff's assertion that he would not have proceeded with the treatment if all of the risks had been made clear to him.<sup>24</sup>

In reaching his conclusion, Potter J followed traditional causation principles. He considered the honesty of the plaintiff but recognised that his mind had only ever been directed to the issue of consent and risks in light of the 'terrible results of his operation', when 'hindsight is almost bound to rule.'<sup>25</sup> Of significance was the fact that the plaintiff had experienced a prolonged period of discomfort and was eager to end it. The historical enquiry drove the outcome of this decision and the judge did not refer to normative questions of what he felt ought to be the outcome, preferring instead to focus on what he determined had happened and was most likely to happen if the requisite advice had been given. The judge did not consider the underlying rationale of the duty, nor did he turn his mind to any harm other than the physical manifestation of a treatment risk. This case represents a straightforward application of principle within existing constraints, and thus, a defeat of the plaintiff's claim.

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<sup>23</sup> Ibid, 329.

<sup>24</sup> Ibid, 330.

<sup>25</sup> Ibid.

The test applied here was a subjective one tempered by objective considerations. The judges asked what this plaintiff would have done but then measured this against what was reasonable. This approach was described by Kennedy as a 'hybrid' or 'modified objective' one in which either evidence of what a reasonable person would have done is tempered by considerations specific to that patient, or the individual assertions of the patient as to how they would have acted are tempered by considerations of what the reasonable person would have done.<sup>26</sup> The nature of the test and the specific problems which arise when confronted with the hypothetical nature of the causation issue in the context of pre-treatment advice is more clearly, and specifically, addressed in the next decision.

*Smith v Barking, Havering & Brentwood Health Authority*<sup>27</sup>

[6.50] The decision in this case also followed traditional causation principles and once again found in favour of the defendant. The essence of the causation problem in 'consent' cases was nicely summarised by Hutchinson J when he noted that he felt a great deal of sympathy for the plaintiff as she was expected to answer hypothetical questions designed to discover what she would have said 'had she been asked questions that she was not asked at a time when she did not know what she now knows.'<sup>28</sup> In determining causation, the Courts are confronted with a series of uncertainties and must endeavour to determine what the most likely sequence of events would have been.

The plaintiff had been ill as a child when she had a cyst drained; there followed a long recovery period after which her symptoms abated and

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<sup>26</sup> I. Kennedy, „Causation Test: Objective or Subjective? *Arndt v Smith* (1998) 6 *Medical Law Review* 126, 128. Kennedy goes on to describe this as an attempt to „steer between polar positions so as to avoid the pitfalls that attend each.“

<sup>27</sup> [1994] 5 Med L.R. 285.

<sup>28</sup> *Ibid*, 289.

she lived a relatively normal life until, at the age of 18, her condition again began to deteriorate. As her health declined, it became clear that the cyst had recurred and that if she did not receive treatment she would at first be confined to a wheelchair and within 6 months, tetraplegia would develop. The Court took care to note that despite skilled surgical intervention the procedure was unsuccessful and the plaintiff suffered immediate and permanent tetraplegia.<sup>29</sup>

The action turned on the failure of Mr Fairburn (the surgeon) to warn her of the risks which all agreed were inherent in the operation and his failure to afford her the opportunity to reach an informed decision as to whether or not to proceed with the treatment.<sup>30</sup> We see here that the argument mounted by the plaintiff mirrors the model advocated by this thesis. It is my position that the denial of opportunity to decide is the true loss sustained. Plaintiffs such as this also argue that it is central to their loss, but the current focus on the potential physical harm means that the Courts are unable to pursue this persuasive line of argument. It is also interesting that the arguments for the plaintiff utilised the language of informed decision-making but this was not pivotal to the reasoning of the judge and in fact, was not mirrored at all in his choice of language. We therefore have a clear divergence between the case as argued by the plaintiff and the case as considered by the judge.

In this case, as in *Smith v Salford*,<sup>31</sup> the judge saw fit to provide some commentary on the behaviour of the surgeon, noting that he was paternalistic in his approach and that he ought to have informed the plaintiff of the risks. The reality of the situation (which was not conveyed to the plaintiff) was that even if the surgery were a clear success it would only ever have provided a brief respite from the

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<sup>29</sup> Ibid, 286-87.

<sup>30</sup> Ibid, 287.

<sup>31</sup> *Smith v Salford Health Authority* [1994] 5 Med L.R. 321, discussed above.

condition and at best, a postponement of tetraplegia. The outcome was inevitable; it was the timing that was the issue. The plaintiff was completely unaware of the realities of her condition and as a result of the over-protective approach of her physician, undertook the surgical procedure believing that there was a good chance of complete cure.

Despite his concern about the approach of the physician, Hutchinson J emphasised that it was not the main issue before the Court. The only significant issue in his view was whether the plaintiff, had she been given the full advice, would have decided against the operation.<sup>32</sup> Whilst the appropriate test was a subjective one, His Honour noted that the Court must take care to approach the question with some objectivity. He explained that in his view, if all factors pointed to the fact that a reasonable plaintiff would have agreed to the operation in the circumstances, then any assertion made after the fact and after having suffered significant injury, that she would not have undertaken the surgery would need to be supported by extraneous factors.<sup>33</sup>

The process adopted here was a reasoned one. The judge explored the broader questions of what would be reasonable in the circumstances; he considered the particular plaintiff and recognised that she found it extremely difficult to determine what she would have done if she had been aware of the risks. A significant consideration was the fact that a probable delay of tetraplegia was a possibility that may well have made the risk worth the taking. This was a decision which turned on the facts before the Court and beyond a mild scolding of the physician, there was no evidence of imposition of external values or attempts to determine what was 'just' or redress any violation of rights. It was, as His Honour explained, a situation of possibilities and probabilities.<sup>34</sup>

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<sup>32</sup> Ibid, 288.

<sup>33</sup> Ibid, 289.

<sup>34</sup> Ibid, 292.

It is illustrative to note the description given by Hutchinson J of the internal conversation undertaken by a patient when confronted with difficult choices such as these. In this instance he simplified the dialogue and suggested that if she had been in possession of the full information, reflection

would have lead a reasonable patient to say to herself: “Well, it seems I’m going to be paralysed anyway in a very short time. This operation gives me a reasonable chance of avoiding that condition perhaps for a few years. True, there is a real risk that the operation will not be successful and I’ll then be paralysed even sooner but the possible benefits clearly considerably outweigh the possible detriment and the chance is one well worth taking.”<sup>35</sup>

We see here the judge, in a somewhat superficial manner, acknowledging the very process that has been denied to the patient. If she had indeed been able to conduct this internal conversation then she would have been aware of all of the options open to her: the choice would have been a truly informed one. To borrow from the High Court, she would have been able to make a ‘meaningful choice.’<sup>36</sup> It is the denial of information which divests the choice of meaning, and it is this divesting of meaning that is the true loss sustained by the plaintiff and the causative link is clear and unproblematic. With the judicial gaze squarely fixed on the manifestation of a different, unrelated harm, the causative enquiry becomes quite complex and, as demonstrated by the next two decisions, infiltrated by inconsistencies and individual perceptions of what ‘ought’ to happen.

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<sup>35</sup> Ibid.

<sup>36</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

*Pearce v United Bristol Healthcare NHS Trust*<sup>37</sup>

[6.60] The two preceding cases demonstrate the clarity of a straightforward application of well-established principles of negligence. They also demonstrate the problematic nature of the current focus on the notion of consent to treatment (as opposed to the process of gathering information and making an informed choice): it makes it extremely difficult for a plaintiff to succeed. The next two decisions adopt contrasting approaches and decline to follow established negligence principles. The result is two anomalous decisions that highlight the flawed nature of the consent enquiry.

Turning first to *Pearce*, we see a Court that was prepared to simply overlook the concept of the autonomous patient and defer entirely to the healthcare profession. As outlined above,<sup>38</sup> Mrs Pearce requested, and was denied, a Caesarian section late in her pregnancy. The Court found that the risk of stillbirth was not 'significant' and that the treating doctor was acting within the bounds of his duty when he failed to inform her of the increased chance of stillbirth if she returned home as advised. The enquiry did not extend much beyond this conclusion. In some interesting *obiter* comments, however, Lord Woolf revealed a strong belief in the traditional approach to determining cause and attributing liability. He was dismissive of the issue of causation in this context because it was difficult to envisage what would have been the consequence if Mrs Pearce had been told of the risk.<sup>39</sup> He went on to imply that it was not really worth considering as it was doubtful that she would have understood what she had been told and it was unlikely that she would have done anything but follow the advice of her doctor.<sup>40</sup> Such a conclusion is unpersuasive when one considers the facts before

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<sup>37</sup> [1999] ECC 167.

<sup>38</sup> Refer discussion in Chapter 3, The Courts: Putting a gloss on the professional standard test (at [3.80]).

<sup>39</sup> *Pearce v United Bristol Healthcare NHS Trust* [1999] ECC 167, [26].

<sup>40</sup> *Ibid.*

the Court: this was her fourth pregnancy, she was distraught and had specifically requested a caesarian section. It is hard to imagine a risk that would be easier to understand in such circumstances.

The approach to causation in this decision, albeit only in *obiter* and very brief, clearly supported the traditional views. It was consistent with the apparent deference accorded to the professional knowledge and expertise of the healthcare profession<sup>41</sup> and avoided using the language of autonomy or notions of what was 'just' and 'right.' Mrs Pearce's internal conversation was irrelevant as was her right to make an informed decision or choice. The approach in *Chester* was somewhat different.

*Manipulating causation: Chester v Afshar*<sup>42</sup>

[6.70] This decision, handed down by the House of Lords, warrants close analysis as it demonstrates the struggle that arises when judges turn their mind to the true nature of the loss and acknowledge that the breach cannot, in any traditional way, be linked to the legally defined loss. The result is a judgment that steps outside of the well-established bounds of negligence law and employs the language of consent, autonomy and justice. This is a step that would not be necessary if the law were focussed on the true loss as opposed to an artificial construction of loss. The Law Lords made it clear in their judgments that the decision was not designed to compensate Mrs Chester for the injury she suffered as the result of the skilfully performed surgery. Rather, it was to compensate her for the infringement of her right to autonomy.<sup>43</sup>

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<sup>41</sup> As demonstrated in the *Bolam* test of duty.

<sup>42</sup> [2005] 1 AC 134.

<sup>43</sup> Maskrey and Edis, above n.11, 215.



Before I outline the concerns I have with this decision, it needs to be acknowledged that the judicial recognition of the infringement of autonomy appears at first blush to be precisely the approach advocated in this thesis; therefore it may initially appear inconsistent to criticise it. The problem I have with *Chester* is not, however, with the spirit of the decision. It is with the fact that it results in incoherent law. The Court is operating within the existing framework that requires the linking of the physical harm with the breach. In the absence of this essential element, the Court simply made a leap across the 'evidentiary gap'<sup>44</sup> and instead of seeking recompense for a loss or injury sustained as a direct result of the breach of duty by the defendant it 'vindicate[d] the violation of a right to choose.'<sup>45</sup> Once again, I recognise that perhaps this thesis ought to be applauding the adoption of such language as, after all, I am advocating the protection of that very right. However, the reasoning of the Court is deeply flawed.

Honoré has noted<sup>46</sup> that an exception to the application of traditional causation is the case where the harm is not within the scope of the rule violated, because the rule is not intended to provide compensation for that type of harm. Here the current framework is intended to compensate for physical harm, not for the loss of autonomy. In *Chester*, the Court turned this reasoning on its head and found that because the harm suffered came within the scope of the rule violated, then there was causation. The causative link to the existing legal definition of harm was glossed over. We will see that the Court concluded that there was no historical link between the failure to inform and the risk of physical harm. This represents a significant departure from established negligence principles that would not be necessary if the doctrine changed to informed choice and put all notions of consent to one side. If the

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<sup>44</sup>J. Stapleton, „Lords A“Leaping Evidentiary Gaps“ (2002) 10 *Torts Law Journal* 276.

<sup>45</sup>*Chester v Afshar* [2005] 1 AC 134, [33] (Lord Hoffman).

<sup>46</sup>A. Honoré, „Medical Non-Disclosure, Causation and risk: *Chappel v Hart*“ (1999) 7 *Torts Law Journal* 1, 15.

Court had been permitted to begin from a different definition of loss, which emanates from the right that was 'violated', then it would have been able to embrace clearly the notions of what was 'just' and operate within the negligence framework. My concern is not with the outcome of the decision but with the path taken by the Court to get there. It is therefore necessary to closely consider that path.

### **The facts and issues**

[6.80] Mrs Chester had a back condition for which she had undergone a number of years of conservative treatment. It became clear that there was need for a more aggressive approach to her treatment and she was referred to Mr Afshar. During her consultation with him, she expressed her concern regarding back surgery and he reassured her that he 'had not crippled anybody yet'<sup>47</sup> and did not inform her of the small (1%-2%), unavoidable risk that she may develop *cauda equina syndrome*.<sup>48</sup> She underwent the procedure within a few days of this consultation. The evidence was that the operation was skilfully performed but she developed the condition and was still suffering at the time of trial. The trial judge found that Mr Afshar's failure to warn had caused the loss but the House of Lords rejected this finding, determining instead that there was no historical link between his failure and her condition and that the only certainty was that she would have delayed the procedure and that such a delay would not have an impact on the likelihood of the risk materialising.<sup>49</sup> However, the majority focussed on the nature of the duty to warn and held that 'justice required a narrow modification of traditional causation principles to vindicate the claimants' right of choice

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<sup>47</sup> *Chester v Afshar* [2005] 1 AC 134, [44].

<sup>48</sup> Explained by Lord Steyn as „serious neurological damage“ [11].

<sup>49</sup> This can be contrasted to the finding in *Chappel v Hart* (1998) 195 CLR 232, in which the delay did alter the risk as she would have sought a more skilled surgeon. This case will be discussed in Chapter 7 (at [7.80]ff).

and to provide a remedy for the breach.<sup>50</sup> Note here the emphasis on a remedy for the breach as opposed to the remedy for a loss as required by established negligence principles.

### **The decision**

[6.90] It is important to acknowledge from the outset that at some level, all questions of duty are driven by policy,<sup>51</sup> but as Khoury<sup>52</sup> points out, there are always two sides to policy considerations. In the 'consent' cases, these two sides represent the interests of the individual patient on the one hand, and the broader societal interest in a proficient medical profession on the other. The question really is, what policy ought to be applied and when?<sup>53</sup> An additional complicating factor is the overarching layer of public interest in a transparent and consistent legal system which relies on well-established principles. This too can be described as a 'policy concern.' The use of the term policy was favoured by all of the Lords in this decision but it must be remembered that it was not always the same 'policy.'<sup>54</sup> A consideration of individual judgments will reveal the malleability, and therefore problematic, nature of policy in this context.

Two of the Lords (in minority)<sup>55</sup> insisted on adhering to the rules of negligence. Lord Bingham, appealed to principle and policy<sup>56</sup> and asserted that to depart from the traditional approach to causation would ensure that the decision was contrary to the 'gist of negligence law'

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<sup>50</sup> *Chester v Afshar* [2005] 1 AC 134. (this summary is taken from the headnote of the reported decision. Individual judgments are considered in detail below).

<sup>51</sup> M. Hogg, „Duties of Care, Causation and the implications of *Chester v Afshar*,“ (2005) 9 *Edinburgh Law Review* 156, 160.

<sup>52</sup> L. Khoury, „*Chester v Afshar*: Stepping further away from causation?“ [2005] *Singapore Journal of Legal Studies* 246.

<sup>53</sup> *Ibid*, 258.

<sup>54</sup> The broader issues of policy and appropriate use of the term will be discussed further in Chapter 10. See also above n.15.

<sup>55</sup> I have chosen to discuss the two minority judgments first as they adhere to traditional causative principles.

<sup>56</sup> His reference to policy was in respect to a consideration of the underlying principles of negligence law.

which he identified as 'damage.'<sup>57</sup> Along with his colleagues, he noted that the central question was whether the conventional approach to causation ought to be varied because of the nature of the duty.<sup>58</sup> He emphasised that 'the existence of the duty was not in doubt and neither was the rationale.'<sup>59</sup> Of significance to him was the fact that there was no clear understanding of what Mrs Chester would have done. Whilst she may have delayed the procedure, she would probably have proceeded at some other time and, significantly, the risk would have 'been the same whenever at whoever's hands she had the operation.'<sup>60</sup> In his view, to allow recovery purely on the basis of a failure to warn, without more, would be a 'substantial and unjustified departure from sound and established principle.'<sup>61</sup>

In Lord Bingham's view, the driving policy consideration was the underlying purpose of negligence law as a whole. He began from the most basic position that the actual damage suffered by the plaintiff is the 'gist of the action in the tort of negligence':<sup>62</sup>

A claimant is entitled to be compensated for the damage which the negligence of another has caused to him or her ... But the corollaries are also true: a claimant is not entitled to be compensated, and a defendant is not bound to compensate the claimant, for damage not caused by the negligence complained of.<sup>63</sup>

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<sup>57</sup> *Chester v Afshar* [2005] 1 AC 134, [9] (Lord Bingham).

<sup>58</sup> *Ibid*, [1], (Lord Bingham)

<sup>59</sup> *Ibid*, [5]. In his view, the rationale is „to enable adults of sound mind to make decisions intimately affecting their own lives and bodies.“

<sup>60</sup> *Ibid*, [7].

<sup>61</sup> *Ibid*, [9]. Contrast this to Lord Steyn's „modest“ departure discussed below.

<sup>62</sup> *Ibid*.

<sup>63</sup> *Ibid*.

His conclusion was based not on what either the plaintiff or defendant *ought* to have done<sup>64</sup> but on what the *law* ought to do:

I do not for my part think that the law should seek to reinforce that right by providing for the payment of potentially very large damages by a defendant whose violation of that right is not shown to have worsened the physical condition of the claimant.<sup>65</sup>

Similarly, Lord Hoffman (also in dissent) began from a position of principle, albeit a narrower one than Lord Bingham. In his view, the appropriate starting point is the purpose of the duty to warn which is to provide the patient with 'the opportunity to avoid or reduce the risk.'<sup>66</sup> He emphasised that the question to be asked was whether one would have taken the opportunity to avoid or reduce the risk, not whether the scenario would have altered in some 'irrelevant detail.'<sup>67</sup> He completely rejected any argument that a delay in the treatment would affect the likelihood of risk. He thought this to be as,

logical as saying that if one had been told, on entering a casino, that the odds on the number 7 coming up at roulette were only 1 in 37, one would have gone away and come back next week or gone to a different casino.<sup>68</sup>

In such a situation, the only difference was in the timing and, as it was generally accepted that a change in timing would not alter the likelihood of the risk then the timing constituted an 'irrelevant detail.'

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<sup>64</sup> As will be seen in the discussion to follow, the majority focused on this question.

<sup>65</sup> *Chester v Afshar* [2005] 1 AC 134, [9] (Lord Bingham).

<sup>66</sup> *Ibid*, [28].

<sup>67</sup> *Ibid*, [31].

<sup>68</sup> *Ibid*.

At the heart of the conclusions of both of these Lords lay adherence to established causative principles and a confirmation of the approaches adopted by the lower Courts in the decisions outlined above. Adherence to orthodox principles was the appropriate 'policy' of the two minority Lords. In contrast to this, the 'policy' of the majority drilled below basic negligence principles and into the underlying ethos of this very specific duty<sup>69</sup> and, in doing so, sidestepped some important mechanisms of negligence law and perhaps, distorted the purpose of the law in order to make it fit.

The majority has been described as a 'triumph of policy,'<sup>70</sup> as if it were one thing. But the interesting aspect of the case is that slightly different 'policy' considerations drove each of the Law Lords as they strove to do 'justice.' Lord Steyn framed his decision so as to loosely bring it within the confines of accepted negligence principles. His rationale was that if Mrs Chester had been warned of the risk, the operation would not have taken place when it did.

What is clear is that if she had agreed to surgery at a subsequent date, the risk attendant upon it would have been the same, i.e. 1%-2%. It is therefore improbable that she would have sustained neurological damage.<sup>71</sup>

His reasoning ran along these lines: because the risk was so slight and it manifested at this time and in these circumstances, the chances of it happening at another time and under different circumstances became even slighter; therefore if she had chosen to delay the treatment then the risk became so slight as to be negligible. In short, he was applying Lord Hoffman's 'casino' rationale. Whilst it is superficially logical, it does not

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<sup>69</sup> That of the doctor to warn their patients of risks.

<sup>70</sup> Khoury, above n.52, 248.

<sup>71</sup> *Chester v Afshar* [2005] 1 AC 134, [11] (Lord Steyn).

stand up to scrutiny. It displays flawed logic that is grounded perhaps more in superstition than statistics.<sup>72</sup>

A significant shift from the duty enquiry first emerged in Lord Steyn's judgment and is indicative of the general trend of this decision, when he retreated into the language of informed consent. Echoing the language of Cardozo J in *Schloendorff* he asserted that:

The starting point is that every individual of adult years and sound mind has a right to decide what may or may not be done with his or her body. Individuals have a right to make important medical decisions affecting their lives for themselves: they have the right to make decisions which doctors regard as ill advised. Surgery performed without the informed consent of the patient is unlawful. The Court is the final arbiter of what constitutes informed consent. Usually, informed consent will presuppose a general warning by the surgeon of a significant risk of the surgery.<sup>73</sup>

Despite a later conclusion that the failure to inform the patient resulted in the injury, he maintained a focus on the nature of the right and emphasised that beyond the historical question lies a normative one.

... a patient's right to an appropriate warning from a surgeon when faced with surgery ought normatively to be regarded as an important right which must be given effective protection whenever possible.<sup>74</sup>

In an endeavour to remain close to established principles, Lord Steyn was the only one to apply the but for test and conclude that

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<sup>72</sup> Refer Lord Hoffman's comments, above n.68.

<sup>73</sup> *Schloendorff v The Society of the New York Hospital* 105 NE 92 at 93 (1914), *Chester v Afshar* [2005] 1 AC 134, [14].

<sup>74</sup> *Chester v Afshar* [2005] 1 AC 134, [17] (Lord Steyn).

... but for the surgeon's negligent failure to warn the claimant of the small risk of serious injury the actual injury would not have occurred when it did and the chance of it occurring on a subsequent occasion was very small. It could therefore be said that the breach of the surgeon resulted in the very injury about which the claimant was entitled to be warned.<sup>75</sup>

Coincident with this conclusion, however, was recognition that the injury to be vindicated here was that done to her right of autonomy and dignity,<sup>76</sup> which warranted a 'narrow and modest departure' from traditional principles.<sup>77</sup> In this judgment we observe a complex balancing act: an effort to maintain orthodox principles at the same time as giving meaning to the underlying ethos (or 'policy') of a duty.

It is in judgments such as these that we are able to see the problem at the heart of the existing doctrine. The true nature of the loss was acknowledged and accorded respect by His Honour but he was unable to legitimately link that harm to the breach of duty. Instead, he had to artificially create a link with the unrelated harm, a step which required a 'modest departure' from established principle. It was in reality more than modest; it required the putting to one side of foundational causative principles. The complete lack of a link was overlooked. If the law recognised the true nature of the loss, then it would not be necessary for the judiciary to turn its face from established principle and 'leap evidentiary gaps'<sup>78</sup> in this manner. The result would be a more transparent and coherent application of negligence principles.

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<sup>75</sup> Ibid, [19], this is merely the conclusion of his earlier rationale.

<sup>76</sup> Ibid, [24].

<sup>77</sup> Ibid.

<sup>78</sup> J. Stapleton, „Lords A“Leaping Evidentiary Gaps“ (2002) 10 *Torts Law Journal* 27.



Turning now to Lord Hope, we see a direct appeal to the function of the law.

The function of the law is to protect the patient's right to choose. If it is to fulfil that function it must ensure that the duty to inform is respected by the doctor. It will fail to do this if an appropriate remedy cannot be given if the duty is breached and the very risk that the patient should have been told about occurs and she suffers injury.<sup>79</sup>

This approach is similar to that advocated in this thesis. His Honour sought to protect the right to choose in appealing to the remedy as a protection of the right to choose, but did not define it as the legally cognisable harm. Instead, he associated the process of choice directly with the duty to inform and the decision to consent to the treatment. His underlying concern was with the protection of rights, but the harm continued to be the manifestation of the physical risk.

In the process of delivering his judgment, Lord Hope acknowledged that the failure to warn did not increase the risk of physical harm, which was likely to occur at random.<sup>80</sup> Instead he appealed directly to the function of the law, the scope of the duty and the need to give effect to the law of informed consent as a means of protecting patient autonomy.<sup>81</sup> This position was echoed by Lord Walker who emphasised the role of the law and the need to ensure that an 'honest plaintiff' not be left without a remedy.<sup>82</sup> Significantly, Lord Walker argued that the Court must not empty an important duty of its content by failing to impose liability.<sup>83</sup>

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<sup>79</sup> Ibid, [56].

<sup>80</sup> Ibid, [61].

<sup>81</sup> Ibid, [56].

<sup>82</sup> Ibid, [101]. Lord Walker is not considered in detail here as he essentially agreed with Lords Steyn and Hope, choosing to add „only a few brief comments of [his] own“ [90]. His brief comments focussed on the individual right to autonomy and the nature of the duty to warn, and served to endorse the comments made by Lord Hope.

<sup>83</sup> [101].

Thus the role of causation became inextricably linked with the content of the duty and questions of whether or not the actual advice given (or not given) truly made a difference, appear to have become secondary.

Whilst it may appear to be a step in the right direction for the Lords to be referring to the nature of the loss and the need to protect the right to choose, neither of these provides the yardstick for measuring the loss.<sup>84</sup> The loss is measured by the manifestation of a physical harm, one that is likely to have occurred whether or not the plaintiff was informed. There is a disjunct between the harm suffered and the remedy provided.<sup>85</sup>

The approach in *Chester* is problematic as it represents a departure from accepted negligence principles, with the Court moving from the arms-length consideration of professional standards which was evident at the duty stage. The focus at the causation stage of the enquiry, as represented by *Chester*, is on questions of what 'ought' to happen. The two approaches do not appear reconcilable. The language of autonomy and informed consent played no role in the development of the duty and standard question in the seminal cases of *Bolam* and *Sidaway*. Yet here, in *Chester*, it was used in order to give effect to the apparent rationale of that duty.<sup>86</sup> The autonomous patient has made a belated appearance and there is an attempt to link the concept of the personal right to information with the manifestation of the physical harm. The illogical nature of such a link is well demonstrated here in *Chester* as we see the Law Lords departing from established principles in an endeavour to construct links which, quite simply, do not exist. If, however, the loss

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<sup>84</sup> During discussions regarding choice and the nature of the loss suffered by the plaintiff I will use the words loss, harm and damage interchangeably. I will however conclude with a clear statement of a model of loss so as to clearly remove this discussion from any consideration of the assessment of „damages“.

<sup>85</sup> Full assessment of the harm suffered by Mrs Chester was not discussed by the House of Lords. As explained by Lord Hope: „The extent of her disability and its consequences have yet to be determined, as that part of the trial was adjourned by the trial Judge pending resolution of the dispute on liability.“ [47]

<sup>86</sup> Refer Lord Bingham referring to the underlying need to make one's own decisions [5], Lord Steyn referred to *Schloendorff* principles and informed consent to give effect to autonomy, [14] and [18]. Lord Hope also introduced the concept of informed consent into his reasoning, [57].

were defined in terms of the denial of this right, there would be no need to search for non-existent links and the Court would be able to act within the negligence framework and the result would be a coherent and consistent law of 'informed choice'.

### *After Chester*

[6.100] Time has passed since the *Chester* decision was handed down in October 2004 and it is illustrative to review its impact. The decision has been considered beyond the confines of the 'informed consent' context and, whilst it has been clearly stated that 'none of the long established authorities on causation were overruled by the House of Lords in *Chester*,<sup>87</sup> its impact on the nature of the causative enquiry cannot be denied.

A consistent theme in subsequent decisions has been the significance of policy considerations. The decision is now interpreted as authority for the proposition that policy, and the concept of justice can justify a departure from well-established principles of causation. The plaintiff in *M's Guardian*<sup>88</sup> 'urged' the Court to 'find causation in the absence of 'but for' and on the basis of policy and corrective justice following *Chester v Afshar*.<sup>89</sup> Lord Bannatyne resisted this argument, referring to *Chester* as 'odd.'<sup>90</sup> In *B v Ministry of Defence*<sup>91</sup> Foskett J described *Chester* as 'authority for the principle that when justice and policy demand it a modification of causation principles is not beyond the wit of the modern Court.'<sup>92</sup>

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<sup>87</sup> *White v Paul Davidson & Taylor* [2004] EWCA 1511, [42] (Aiden LJ).

<sup>88</sup> *M's Guardian v Lanarkshire Health Board* [2010] CSOH 104.

<sup>89</sup> *Ibid*, [162] (Lord Bannatyne).

<sup>90</sup> *Ibid*, [268].

<sup>91</sup> *B v Ministry of Defence* [2009] EWHC 1225 (QB).

<sup>92</sup> *Ibid*, [218] (Foskett J).

Similarly, Baroness Hale suggested that *Chester* demonstrates how ‘well settled principles may be developed or modified to meet new situations if the Court cannot do justice without doing so.’<sup>93</sup> And in *DN v Greenwich LBC*<sup>94</sup> Brooke LJ accepted that ‘justice’ may well demand a ‘different approach’ to otherwise well-established principles.<sup>95</sup> *Chester* has also provided support for Courts blurring the breach and causation lines of enquiry and choosing, when attributing responsibility for harm, to focus on the purpose of a duty as opposed to traditional causative links between breach and harm.<sup>96</sup> Overall, *Chester* gives authority to ‘stretch conventional notions of causation to the limit’<sup>97</sup>, ‘liberalising the but for test of causation’<sup>98</sup> and a ‘departure from established principle.’<sup>99</sup>

Thus *Chester*, in struggling to link a dignitary harm with a physical loss, has come to represent a shift away from established negligence principles. It is important to recognise that a departure from established principle may, indeed, be appropriate at times. As the theme of this thesis represents a shift in focus from one form of loss to another, I am clearly not advocating for a law that never evolves or changes. Neither am I denying the relevance of well articulated and defined policy considerations along with conceptions of justice (both of which are explored in *Chester*). The concern here is that this struggle is not necessary and neither is the situation in ‘informed consent’ decisions ‘special,’<sup>100</sup> ‘exceptional’<sup>101</sup> or ‘odd.’<sup>102</sup> What we have in the ‘informed consent’ decisions is an example of Courts struggling to identify links

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<sup>93</sup> *Gregg v Scott* [2005] 2 AC 176, [192] (Baroness Hale).

<sup>94</sup> [2004] EWCA Civ 1659.

<sup>95</sup> *Ibid*, [71].

<sup>96</sup> *Calvert v William Hill Credit Ltd* [2008] EWCA Civ, Lloyd and Etherton LJ held that *Chester* is authority for the proposition that the Court can decline to apply a test for causation which would have the effect of stripping the duty of all practical force and content [34], whilst in *Mosley v News Group Newspapers Ltd* [2008] EWHC 1777 Eddy J pointed out that it is accepted in recent jurisprudence that a legitimate consideration is that of vindication to mark the infringement of a right.

<sup>97</sup> *M v Mid Yorkshire Hospitals NHS Trust* [2005] EWHC 3469 (QB), [60] (Langdon J).

<sup>98</sup> *Prison Service v Beart (No 2)* [2005] EWCA 467, [39] (Rix LJ).

<sup>99</sup> *Fotadar v St George’s Healthcare NHS Trust* [2005] EWHC 1327, [64] Gray J.

<sup>100</sup> *White v Davidson & Taylor* [2004] EWCA 1511, [41] (Aiden LJ).

<sup>101</sup> *Beary v Pall Mall Investments* [2005] EWCA 415 [38], (Dyson LJ).

<sup>102</sup> *M’s Guardian v Lanarkshire Health Board* [2010] CSOH 104, [268] (Bannatyne LJ).

that simply do not, and cannot, exist. If the true loss were acknowledged then causation would be straightforward and even truly ‘modest’<sup>103</sup> departures from established principles would not be necessary.

## **Re-visiting the core issues**

[1.110] Before leaving the United Kingdom and moving on to our other jurisdictions I will address each of the questions asked at the beginning of this Part of our discussion. The same approach will be adopted in the context of each of the other jurisdictions and then, once again, the apparently different tests will be applied to Sally. This will clearly demonstrate the ongoing struggle facing Courts seeking to link the loss of a right to choose with an unrelated physical harm.

### *What is the test for causation (is it subjective or objective)?*

[6.120] Before *Chester* stepped outside of established approaches to causation, the Courts applying traditional principles developed a hybrid approach. The basis of this approach was judicial recognition of the challenge to a plaintiff when required to honestly evaluate what they would have done in hypothetical circumstances. The hybrid test was clearly set out by Hutchinson J in *Smith v Barking, Havering & Brentwood Health Authority*<sup>104</sup> when His Honour recognised that establishing causation begins with a subjective test, based upon that particular plaintiff. He went on to explain that the hypothetical nature of the enquiry meant that it must be tempered by objective considerations such as what the reasonable plaintiff would have done.<sup>105</sup> As we have seen, however, since that time the issue has become broader than a mere

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<sup>103</sup> *Chester v Afshar* [2005] 1 AC 134, [24] (Steyn LJ).

<sup>104</sup> [1994] 5 Med L.R. 285.

<sup>105</sup> *Ibid*, 289 (Hutchinson J).

question of subjective or objective test and other issues<sup>106</sup> have become relevant.

*What factors influenced the development of the test in each jurisdiction?*

[6.130] The pre-*Chester* decisions, in developing the hybrid test of causation, were influenced by the hypothetical question that they were forced to answer. The move beyond the bounds of traditional questions of causation was largely influenced by the *Chester* Courts' recognition of the limitation of established principles as a means to protect the right at the heart of the 'informed consent' decisions. Under *Chester* we see the importation of considerations such as the nature of the duty, dictates of policy and questions of justice. Whilst the more traditional Courts had clearly rejected this approach it was clearly unacceptable to the House of Lords that the plaintiff, who had clearly suffered harm, would not be able to recover. Instead of clearly addressing the true nature of the loss sustained defined by Lord Hoffman as 'the violation of a right to choose,'<sup>107</sup> the Court opted to 'fearlessly embrace policy'<sup>108</sup> and sought to avoid 'emptying an important duty of its content.'<sup>109</sup> The result has been a shifting of the bounds of causation and an approach that has been given broader application than the narrow, fact-driven considerations raised by the House of Lords.

*What (if anything) is the problem with the chosen approach?*

[6.140] The discussion in *Chester*, and to an extent, later cases demonstrates a dissatisfaction with the notion of linking the loss of the ability to exercise a personal right with the manifestation of a physical harm. The earlier decisions were equally uneasy about traditional

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<sup>106</sup> These include concepts of justice, the rationale behind duty of care and autonomy.

<sup>107</sup> *Chester v Afshar* [2005] 1 AC 134, [33] (Lord Hoffman).

<sup>108</sup> Brahams, above n.10, 114

<sup>109</sup> *Chester v Afshar* [2005] 1 AC 134, [101] (Lord Hope).

principles noting that causation is a vexed question because it is based on a purely hypothetical enquiry. Therefore, even if subsequent Courts seek to distinguish the facts before them from those in *Chester* (perhaps by describing *Chester* as ‘odd’<sup>110</sup> or finding that it ‘does not establish a new general rule in causation’<sup>111</sup>), the search for the causative link is not straightforward.

In both the hybrid approach (represented by *Smith v Barking, Havering & Brentwood Health Authority*<sup>112</sup>) and the policy based approach (represented by *Chester v Afshar*<sup>113</sup>) we see an ongoing struggle to reconcile what the judiciary instinctively recognises as the true nature of the loss sustained with the existing negligence framework and reliance on the manifestation of a physical harm. The adoption of policy is perhaps aimed at legitimising the malleable application of causation principles but it is undermined by the inconsistent and individual interpretations of what policy is the appropriate one in these circumstances. We will see in later discussions that this thesis does not challenge the relevance of policy. Rather it is the individual nature of the ‘policy’ considerations adopted by different members of the judiciary that causes concern.<sup>114</sup>

The problem at the heart of both of the approaches found in the United Kingdom is that there is an importation of value-based evaluations which result in incoherent law. This would not be necessary if the Courts were able to openly define the harm as the loss of a right to choose and seek to link that harm with the failure to adequately inform.<sup>115</sup> Similar problems arise in both Australia and the United States

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<sup>110</sup> *M's Guardian v Lanarkshire Health Board* [201] CSOH 104, [268] (Bannatyne LJ).

<sup>111</sup> *White v Davidson & Taylor* [2004] EWCA 1511, [40] (Aiden LJ).

<sup>112</sup> [1994] 5 Med L.R. 285.

<sup>113</sup> [2005] 1 AC 134.

<sup>114</sup> Refer to Chapter 9 for the discussion of the policy diversion.

<sup>115</sup> Central to this is, of course, the material nature of the omitted information.

and, as we shall see in the following Chapters, an equally unsatisfactory resolution has been found.



## Chapter 7: Australia

### Introduction

[7.10] In Australia the question of causation has presented most plaintiff patients with an insurmountable obstacle. Much of the judicial debate about causation has turned on questions of the nature of the test (subjective or objective) and the onus of proof. There has been a complete absence of discussion about the nature of the loss sustained and the limitation of personal choice-making authority, which was relevant when discussing duty, is put to one side. The decisions turn on whether or not the patient would have agreed to undergo the treatment, with the focus of judicial attention being entirely on the manifestation of a physical harm as opposed to the removal of authority from the patient. At this stage of the enquiry we see that the primary concern is consent (a creature of trespass). The provision of advice, the measure of standard and therefore of negligence, becomes secondary.<sup>1</sup>

Before examining the decisions in detail, it is important to recognise that whilst the test for causation is primarily subjective, it is not wholly so. Australian Courts, similarly to those in the United Kingdom, have recognised the problematic nature of relying on assertions based upon purely hypothetical situations ('hindsight bias')<sup>2</sup> but, instead of turning to an objective test (which as we will see is the path taken in the United States), have opted to exercise caution. The High Court has emphasised that 'tribunals of fact can be trusted to reject absurd, self-interested assertions'<sup>3</sup> and are therefore unlikely to be misled by self-serving evidence. The Courts, in seeking to walk a middle ground, have created a hybrid test in

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<sup>1</sup> A preliminary note must be made here that there has been legislative intervention in all Australian jurisdictions. This will be explored in more detail below.

<sup>2</sup> „Review of the law of Negligence Final Report“, Sep 2002 („The Ipp Report“) [http://revofneg.treasury.gov.au/content/Report2/PDF/Law\\_Neg\\_Final.pdf](http://revofneg.treasury.gov.au/content/Report2/PDF/Law_Neg_Final.pdf), at 18 February 2011), [7.40].

<sup>3</sup> *Chappel v Hart* (1998) 195 CLR 232, 273 (Kirby J).

which subjective assertions of the plaintiff-patient are tempered by considerations of what an objective patient would have done under the circumstances.<sup>4</sup> And, in four jurisdictions, the subjective test is specifically retained but the plaintiff-patient is not permitted to assert what they would, or would not have done:

- (3) If it is relevant to deciding factual causation to decide what the person who suffered harm would have done if the person who was in breach of the duty had not been so in breach--
  - (a) the matter is to be decided subjectively in the light of all relevant circumstances, subject to paragraph (b); and
  - (b) any statement made by the person after suffering the harm about what he or she would have done is inadmissible except to the extent (if any) that the statement is against his or her interest.<sup>5</sup>

What we see in Australia are firm reservations about the subjective test, combined with a disinclination to adopt an objective one. This does not, however, result in a clear or balanced test and plaintiff-patients continue to be denied recompense for the loss of personal authority.

## **Appeals to commonsense**

[7.20] Causation has had a chequered history in the common law world and, as noted by the Supreme Court of Canada, ‘much judicial and academic ink has been spilled over the proper test for causation.’<sup>6</sup> Historically, Courts have struggled with the identification of an appropriate test for causation which

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<sup>4</sup> See for example, *Rosenberg v Percival* (2001) 205 CLR 434, *Micallef & Anor v Minister for Health of the State of WA* [2006] WASCA 98, [64] (McLure JA) and *Wallace v Ramsay Health Care Ltd* [2010] NSWSC 518, [72] (Harrison J). These and other decisions will be discussed in more detail below.

<sup>5</sup> *Civil Liability Act 2002* (NSW) s5D(3), *Civil Liability Act 2003* (QLD) s11(3), *Civil Liability Act 2002* (TAS) s13(3) and *Civil Liability Act 2002* (WA) s5C(3), the wording in the Western Australian Act is slightly different but the application would be the same.

<sup>6</sup> *Resurface Corp v Hanke* [2007] 1 SCR 333, [20].

has been outlined and dealt with elsewhere.<sup>7</sup> For present purposes it is sufficient to note that the judiciary in Australia has stepped away from a factual or historical approach to causation and rejected the 'but for' test as determinative.<sup>8</sup> The driving consideration has been described as 'common sense' in an endeavour to separate the legal question of causation from 'philosophical and scientific notions.'<sup>9</sup> Mason CJ explained the distinction between philosophy or science and law in the following terms:

In philosophy and science, the concept of causation has been developed in the context of explaining phenomena by reference to the relationship between conditions and occurrences. In law on the other hand, problems of causation arise in the context of ascertaining or apportioning legal responsibility for a given occurrence.<sup>10</sup>

In the same case, Dean J emphasised that causation is the 'attribution of fault or responsibility'<sup>11</sup> and McHugh J referred to the question of whether a defendant 'should be held legally responsible.'<sup>12</sup> The rationale behind this conceptual shift was described by McHugh J as the underlying purpose of the causation enquiry (at law), that is, 'to allocate legal responsibility.'<sup>13</sup> Thus it is the position of the High Court that when one is attempting to determine causation on a philosophical or scientific level, it is a matter of addressing cause and effect: did event A clearly result in event B. At law, however, the notion of causation is embedded in the more intangible question of

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<sup>7</sup> See C. Sappideen and P.Vines (ed), *Fleming's The Law of Torts*, (10<sup>th</sup> ed, Thomson-Reuters, Sydney, 2011), Chapter 9, B. Richards, K.Ludlow and A. Gibson, *Tort Law in Principle*, (5<sup>th</sup> ed, Thomson-Reuters, Sydney, 2009), Chapter 11, R.P. Balkin and J.L.R Davis, *Law of Torts* (4<sup>th</sup> ed, LexisNexis Butterworth, Sydney, 2009), Chapter 9 and H.Luntz, D.Hambly, K.Burns. J.Dietrich and N.Foster, *Torts Cases and Commentary* (6<sup>th</sup> ed, LexisNexis Butterworths, Sydney, 2009), Chapter 4.

<sup>8</sup> See *March v Stramare* (1991) 171 CLR 506, 508 (Mason CJ), 522 and 523 (Deane J) and 524 (Toohey J).

<sup>9</sup> *Ibid*, 509 (Mason CJ), 522 (Deane J) and 529 and 530 (McHugh J).

<sup>10</sup> *Ibid*, 509 (Mason CJ).

<sup>11</sup> *Ibid*, 522 (Deane J).

<sup>12</sup> *Ibid*, 529 (McHugh J).

<sup>13</sup> *Ibid*.

responsibility and therefore becomes a normative enquiry in which 'considerations of policy and value judgments may necessarily enter.'<sup>14</sup>

Interestingly the 'common sense' approach which was, according to the Judges, developed to accommodate notions of justice and responsibility and separate legal from scientific cause, has been interpreted in different ways. Honoré, for example, has suggested that 'the notion of cause is the same in law, medicine, science and everyday life. This point is one that common law judges have often stressed, when they say that causation in law is a matter of common sense.'<sup>15</sup> Cane has warned that 'saying that causation is a matter of 'common sense', 'intuition' or 'fact' does not absolve a judge from the hard task of analysing the concepts and issues underlying these opaque terms.'<sup>16</sup> Milstein has noted that 'common sense is an uncertain guide which does not lead everyone to the same conclusion,'<sup>17</sup> whilst Clarke has described common sense as 'worrying indeed.'<sup>18</sup> Analysis of some key decisions will demonstrate that Cane's warning was a timely one and that, in practical terms, the 'common sense' discussion has lent little clarity. Instead it has enabled the intrusion of individual views of what is the appropriate outcome in the specific circumstances before the Court.

In response to the ongoing judicial and scholarly debate regarding the test for causation, there has been legislative reform in Australia. This reform was aimed at more clearly setting out the causative test,<sup>19</sup> but in practical terms

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<sup>14</sup> Ibid, 524 (Toohey J). The foundational concept of responsibility is also discussed by Mason CJ at 509, Deane J at 522 and McHugh J at 530 and 531 where he refers to value judgments and moral responsibility. It is worth noting that Gaudron J agreed with Mason CJ and Deane J.

<sup>15</sup> A. Honoré, „Principles and Values Underlying the Concept of Causation in Law,“ in I. Freckelton and Danuta Mendelson (eds), *Causation in Law and Medicine* (Ashgate/Dartmouth, Aldershot, 2002) 3, 3-4. The role of common sense and policy will be considered closely in Chapter 10.

<sup>16</sup> Peter Cane, „A Warning About Causation“ (1999) 115 *Law Quarterly Report* 21, 27.

<sup>17</sup> Bob Milstein, „Causation in Medical Negligence – Recent Developments“ (1997) 6 *Australian Health Law Bulletin* 21, 22.

<sup>18</sup> Jeremy Clarke, „Causation in Chappel v Hart: Common Sense or Coincidence?“ (1999) 6 *Journal of Law and Medicine* 335, 347.

<sup>19</sup> This reform was on the recommendation of the „Ipp Review of Negligence.“ Australia, „Review of the law of Negligence Final Report“, Sep 2002 („The Ipp Report“) [http://revofneg.treasury.gov.au/content/Report2/PDF/Law\\_Neg\\_Final.pdf](http://revofneg.treasury.gov.au/content/Report2/PDF/Law_Neg_Final.pdf), at 18 February 2011, [7.28]-[7.36]. The relevant legislative provisions are: *Civil Law (Wrongs) Act 2002* (ACT) Part 4.4, *Civil Liability Act 2002* (NSW), s5D, *Civil Liability Act 2003* (Qld), Ch 2, Pt. 1 Div.2, *Civil Liability Act 1936* (SA) Part 6, Div 4, *Civil*

has simply enshrined the judicial mix of a factual and normative enquiry.<sup>20</sup> The High Court recently emphasised that causation is now governed by the relevant Act<sup>21</sup> and suggested that this may differ from the ‘common sense approach of *March v Stramare*,’<sup>22</sup> which the Court described as a rejection of the relevance of value judgments in the determination of causation as an issue of fact.<sup>23</sup> This did not serve to clarify the test however, as the Court declined to examine exactly how (or indeed if) the outcome would differ if *March*, as opposed to the legislation, were applied.<sup>24</sup> The legislative test was explained by the High Court as dividing the enquiry into two elements: ‘factual causation and scope of liability,’<sup>25</sup> an approach which is consistent with earlier judicial considerations of causation in the context of ‘informed consent.’

Decisions, which have considered the legislative provisions in the context of pre-treatment advice, are limited but there is clear judicial support for the view that the law has not shifted significantly with the introduction of the legislation. The New South Wales Supreme Court applied the *Civil Liability Act 2002* (NSW) in *Wallace v Ramsay Health Care Ltd*<sup>26</sup> and after acknowledging the authority of the Act and the two phases as explained in *Adeels Palace*<sup>27</sup> went on to follow the approach of the High Court in *Rosenberg*<sup>28</sup> and demonstrated that these earlier authorities are consistent with the newer legislative provisions. A further point of ‘clarification’ introduced

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*Liability Act 2002* (Tas) Div 3, *Wrongs Act 1958* (Vic), Part X, Div 3, *Civil Liability Act 2003* (WA) Part 1A, Div 3.

<sup>20</sup> For further discussion see S.Bartie, „Ambition Versus Judicial Reality: Causation and Remoteness Under Civil Liability Legislation“ (2007) 33 *University of Western Australia Law Review* 415.

<sup>21</sup> *Adeels Palace Pty Ltd v Moubarak* (2009) 239 CLR 420, [41] (French CJ, Gummow, Hayne, Heydon and Crennan JJ).

<sup>22</sup> *Ibid*, [44].

<sup>23</sup> *Ibid*, [43].

<sup>24</sup> *Ibid*, [44].

<sup>25</sup> *Ibid*, [41]-[43]. See for example the South Australian provision:

s34(1)A determination that negligence caused particular harm comprises the following elements:  
 (a) that the negligence was a necessary condition of the occurrence of the harm ("factual causation");  
 and  
 (b) that it is appropriate for the scope of the negligent person's liability to extend to the harm so caused ("scope of liability").

*Civil Liability Act 1936* (SA) s32. All other states have equivalent provisions.

<sup>26</sup> [2010] NSWSC 518.

<sup>27</sup> *Ibid*, [72] (Harrison J).

<sup>28</sup> *Rosenberg v Percival* (2001) 205 CLR 434.

in the legislation is the addition, introduced above, that that causation is determined subjectively but that 'any statement made by the person after suffering the harm about what he or she would have done is inadmissible except to the extent (if any) that the statement is against his or her interest.'<sup>29</sup> This appears to be a subjective test with limited emphasis on the plaintiff-patient evidence, thus removing a vital element from the plaintiff's case. In practical terms, however, it does not appear to be the case. In delivering his judgment in *Wallace*<sup>30</sup> Harrison J cited the Act, referred to the relevant section (s5D(3)(a)) and noted that the test was subjective but chose not to comment on the evidential limitation.<sup>31</sup> He then went on to specifically explore the credibility of the plaintiff's evidence and openly rejected it.

I would suggest therefore that the impact of the legislation on the judicial approach to causation in the 'informed consent' decisions is limited. The New South Wales Court of Appeal expressed a similar view in *Neal v Ambulance Service of New South Wales*<sup>32</sup>, with Basten JA concluding that 'properly understood, the prohibition on evidence from the plaintiff about what he or she would have done is of quite limited scope.'<sup>33</sup> Similarly, in *KT v PLG & Anor*<sup>34</sup> the Court excluded evidence of what the plaintiff would have done in those specific circumstances but recognised the relevance of the surrounding circumstances.<sup>35</sup> These circumstances and 'relevant considerations' were listed in *Neal* as including:

- a. conduct of the plaintiff at the relevant time;
- b. evidence of the plaintiff as to how he or she might have felt about particular matters;

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<sup>29</sup> *Civil Liability Act 2002* (NSW) s5D, *Civil Liability Act 2003* (QLD) s11, *Civil Liability Act 2002* (TAS) s13 and *Wrongs Act 1958* (Vic) s51.

<sup>30</sup> *Wallace v Ramsay Health Care Ltd* [2010] NSWSC 518.

<sup>31</sup> *Ibid*, [72] (Harrison J).

<sup>32</sup> [2008] NSWCA 346.

<sup>33</sup> *Ibid*, [41] (Basten JA).

<sup>34</sup> [2006] NSWSC 919.

<sup>35</sup> *Ibid*, [43] (Simpson J).

- c. evidence of others in a position to assess the conduct of the plaintiff and his or her apparent feelings or motivations; and
- d. other matters which might have influenced the plaintiff.<sup>36</sup>

and reflect those endorsed by the High Court in *Rosenberg v Percival*<sup>37</sup> (to be discussed below). In exploring the Australian approach to causation I therefore begin with a recognition of the legislative reform but take my guidance from the scholarly and judicial commentary that suggests that the legislation acts to endorse rather than change the preferred approach of the High Court. This approach is consistent with that of Gleeson and Evans who suggested that 'the statutory inadmissibility of the plaintiff's evidence now renders the situation similar to the common law position elucidated in *Rosenberg v Percival*'<sup>38</sup> and more recently, Cockburn and Madden have asserted that 'arguably the judicial process will not differ greatly as between those jurisdictions with the Civil Liability legislation evidence exclusion and those without.'<sup>39</sup> I will therefore refer primarily to the common law and judicial statements of causative principles, and not the legislation where relevant.

## The case law

### *Nature of the test*

[7.30] Turning now to the 'informed consent' decisions, a close consideration of relevant case law reveals that whilst the negligence enquiry is clearly a staged one,<sup>40</sup> the question of causation inevitably rests upon the nature and

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<sup>36</sup> *Neal v Ambulance Service of NSW* [2008] NSWCA 346, [40] (Basten JA).

<sup>37</sup> (2001) 205 CLR 434.

<sup>38</sup> J.Gleeson SC and G. Evans, „The Question that Plaintiff's Counsel Cannot Ask“ *Bar News* Summer 2004/2005, 36, 38.

<sup>39</sup> T. Cockburn and B.Madden, „Proof of Causation in Informed Consent Cases: Establishing what the plaintiff would have done“ (2010) *Journal of Law and Medicine* 320, 332. The scholarly consideration of the reform is limited but consistent with my interpretation of the case law.

<sup>40</sup> Identification of duty, determination of breach and then causation.

purpose of the duty of care. In *Chappel v Hart*<sup>41</sup> for example, when addressing the issue of causation Kirby J reminded us that the 'requirement to warn about risks is an important one conducive to respect for the integrity of the patient and better health care ... the law intends its obligations to be carefully observed. Breaches must be treated seriously.'<sup>42</sup> The necessary implication was that if there is a breach of this significant duty, the Court will seek to attach liability for the breach, even in the face of uncertain causation. We will see, however, that this is not often the case with Courts finding themselves limited by the legal requirement that this respect for patient integrity be linked to the manifestation of a physical harm.

In addition to the nature of the duty, the Court must deal with the rationale behind its imposition. The plaintiff before the Court will have suffered a physical injury but the interest to be protected by the duty to inform is more than mere physical wellbeing. It is the individual right to information.<sup>43</sup> These core concerns when combined with the attribution of responsibility underpinning the causation enquiry have meant that the High Court, similarly to the House of Lords in *Chester v Afshar*,<sup>44</sup> has been influenced by the need to redress a perceived wrong (the failure to warn). Once again we see the Courts struggling to reach the desired destination (liability and recompense for a wrong), but unable to do so because of conceptual difficulty of identifying a link between a dignitary harm and a physical loss. The stringent requirement of causation makes it impossible to take a direct and simple route.

This enquiry is further complicated by the debate regarding the appropriate test. Ought the causative question be answered subjectively (what would

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<sup>41</sup> (1998) 195 CLR 232.

<sup>42</sup> *Chappel v Hart* (1998) 195 CLR 232, [93] (Kirby J). This is a theme he developed further in *Rosenberg v Percival* (2001) 205 CLR 434, [154], when discussing the need for the test for causation to be consistent with the principles of tort law and the requirements of *Rogers v Whitaker* (1992) 175 CLR 479, (at [157]).

<sup>43</sup> Note Jeremy Clarke, „Causation in *Chappel v Hart*: Common Sense or Coincidence?“ (1999) 6 *Journal of Law and Medicine* 335, 337, and analysis of *Chappel v Hart* (1998) 195 CLR 232 and other decisions below.

<sup>44</sup> [2005] 1 AC 134, refer Chapter 6 (at [6.70]).



that particular patient have done if in possession of an appropriate level of information), or objectively (what would the reasonable patient in that position have done if in possession of an appropriate level of information)? Whilst there has been a great deal of judicial energy expended on this debate, as we will see in the following discussion, there is little difference between the practical application of the two tests.<sup>45</sup> It is my position that the reason that there is little practical difference lies in the inappropriateness of attempting to link a physical loss to a dignitary harm.

### *A subjective test informed by objective considerations*

[7.40] Australian Courts have consistently emphasised the importance of the patient as a decision-maker. From the beginning of the negligence enquiry, the individual before the Court has been central to the investigation. If we return to the *Rogers v Whitaker* materiality test,<sup>46</sup> the significant question was whether that particular patient would have deemed the information material to their decision-making process and, fleetingly, the concept of choice was introduced. Maintaining this patient focus has meant that Australian Courts have purported to adopt a subjective approach to causation in the context of pre-treatment advice.<sup>47</sup> The High Court has not specifically debated the issue but both *Chappel v Hart*<sup>48</sup> and *Rosenberg v Percival*<sup>49</sup> affirmed earlier Supreme Court decisions. Despite clear affirmation of a subjective approach, however, the High Court has adopted a tempered or hybrid version of the subjective test by measuring the evidence of the plaintiff against evidence of what a reasonable person in the plaintiff's position would have done.<sup>50</sup>

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<sup>45</sup> This will once again be demonstrated at the end of this Part of the discussion when we apply the different tests to Sally's situation.

<sup>46</sup> (1992) 175 CLR 479, refer above Chapter 4.

<sup>47</sup> As indicated above this has been endorsed by legislation in four jurisdictions: adopted by the Civil Liability regime: *Civil Liability Act 2002* (NSW) s5D(3), *Civil Liability Act 2003* (QLD) s11(3), *Civil Liability Act 2002* (TAS) s13(3) and *Civil Liability Act 2002* (WA) s5C(3).

<sup>48</sup> (1998) 195 CLR 232, 272 (Kirby J), affirming *Gover v South Australia* (1985) 39 SASR 543 and *Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553.

<sup>49</sup> (2001) 205 CLR 434, 462 (Gummow J) (affirming *Gover v South Australia* (1985) 39 SASR 543 and *Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553) and 485-486 (Kirby J, affirming *Ellis*).

<sup>50</sup> *Rosenberg v Percival* (2001) 205 CLR 434 provides an excellent example of the relevance of objective factors and will be considered in detail below.

The rationale behind the adoption of a subjective test of causation is consistent with that behind the imposition of the duty to warn. In *Ellis v Wallsend District Hospital*,<sup>51</sup> Kirby P pre-empted some of his later discussions in the High Court when he noted that the subjective test for causation is appropriately deferential to ‘respect for the integrity of the patient as an individual ... hav[ing] command over his or her body.’<sup>52</sup> He recognised that there are problems with the subjective approach as it ‘involves an exercise of retrospective reasoning’ and ‘however honest the patient may try to be, self-interest and the knowledge of the misfortunes that have followed the treatment will necessarily colour the patient’s response.’<sup>53</sup> He further developed this theme in *Chappel v Hart*<sup>54</sup> when he once again mentioned the ‘malleability of recollection even of an upright witness’ but noted that the ‘dangers should not be over-stated. Tribunals of fact can be trusted to reject absurd, self-interested assertions.’<sup>55</sup> Note, however, that the emphasis is on the right to determine what is or is not done and thus is implicitly about consent, as opposed to the individual right to information. The investigation is now centred on the issue of bodily integrity and the decision to proceed (or not) with the treatment. This is a subtle but significant shift from the right to material information which drives the standard enquiry and is purportedly at the base of the whole process. It is this shift that dilutes the enquiry and undermines the personal process of choice.

The subjective test is not a straightforward one. In those jurisdictions where plaintiff evidence is permitted, the Court is not bound to accept it.<sup>56</sup> There

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<sup>51</sup> (1989) 17 NSWLR 553.

<sup>52</sup> *Ibid*, 560 (Kirby P).

<sup>53</sup> *Ibid*.

<sup>54</sup> (1998) 195 CLR 232.

<sup>55</sup> *Ibid*, 272-273 (Kirby J). Observations repeated in *Rosenberg v Percival* (2001) 205 CLR 434, 467 and 486. For an example of such a process, refer *Bustos v Hair Transplant* Unrep, NSWCA, 15 April 1997.

<sup>56</sup> Indeed, plaintiff evidence in medical negligence in general is generally treated with a healthy amount of scepticism, see for example, *Bustos v Hair Transplant* Unrep, NSWCA 15 April 1997, as well as *Bergman v Haertsh* [2000] NSWSC 528, [51] where Abadee J specifically suggested that patients’ ‘expectations will often exceed entitlement’ and *Micallef & Anor v Minister for Health of the State of WA* [2006] WASCA 98, [64] in which we see McLure JA discussing the process of ‘test[ing] the patients’ credibility.’

will always be individual assessments of what is the 'truth.' It is left to the primary judge to determine whether or not the plaintiff's evidence is credible and it is at this point of the enquiry that the subjective evidence is set alongside objective criteria of what a reasonable patient in that position would have done.<sup>57</sup> This does not always end favourably for the plaintiff as was demonstrated in the New South Wales Court of Appeal decision of *Bustos v Hair Transplant*.<sup>58</sup> The appellant, who was concerned about his receding hairline, had been impressed by a transplant operation performed on his uncle. He actively sought the same treatment<sup>59</sup> and later experienced some unfortunate side effects including drooping of his face and incomplete coverage of his head. It was noted by the Court of Appeal that the primary judge found the evidence of the appellant to be 'coloured and unreliable'<sup>60</sup> and that he had been 'keen to the point of desperation' to have the treatment with a 'picture in his mind's eye of his rejuvenated uncle.'<sup>61</sup> The decision turned entirely on the impression of the plaintiff before the Court and his evidence was rejected outright.

Similarly in *Bergman v Haertsch*<sup>62</sup> when the Court was confronted with a complex case considering patient dissatisfaction with gender reassignment surgery,<sup>63</sup> individual impressions of credibility were central to the outcome. In the process of delivering his judgment, Abadee J repeatedly and emphatically rejected the evidence of the plaintiff, describing her as an 'unreliable and unsatisfactory witness.'<sup>64</sup> And in *Wallace v Ramsay Health Care Ltd*<sup>65</sup> when considering the situation of a plaintiff who was disappointed with

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<sup>57</sup> *Micallef & Anor v Minister for Health of the State of WA* [2006] WASCA 98, [64] McLure JA explained that „the test for causation is subjective although objective factors are used to test the patients' credibility.“ And as we saw in the discussions above, the Courts in four jurisdictions (NSW, Qld, Tas and Vic) now have legislative authority to decline patient evidence, refer above text accompanying n.5.

<sup>58</sup> Unrep, NSWCA, 15 April 1997.

<sup>59</sup> A „Juri flap“ which later fell into disfavour but was appropriate and acceptable in 1982. Ibid, [2].

<sup>60</sup> *Bustos v Hair Transplant* Unrep, NSWCA, 15 April 1997, Gleeson CJ [7].

<sup>61</sup> Ibid, [22].

<sup>62</sup> [2000] NSWSC 528.

<sup>63</sup> I describe this case as complex because it dealt with claims in contract, negligence and assault. This discussion will, of course, focus on the negligence discussion.

<sup>64</sup> *Bergman v Haertsch* [2000] NSWSC 528, [89]. See also [91] where His Honour rejected her credibility and [54] when he referred to the „clear evidence that she was seeking perfection.“

<sup>65</sup> [2010] NSWSC 518.

the outcome of back surgery, Harrison J delivered part of his judgment under the heading 'Credit' and specifically addressed the character of both the plaintiff and the defendant, along with the character of their evidence. In the process His Honour noted that 'the assessment of the plaintiff as a patient and as a witness is critical at this [the causative] stage of the enquiry'<sup>66</sup> and repeatedly referred to the fact that the patient was 'desperate'<sup>67</sup> and was able to conclude that 'it is to my mind inconceivable, or at least highly unlikely that the plaintiff would have hesitated for a moment to submit to [the] procedure.'<sup>68</sup>

Whilst the decisions in each of these cases appear to be entirely reasonable in the circumstances,<sup>69</sup> this is not always the case. The reliance on impressions of the plaintiff and his or her evidence can come down to individual character traits and personal responses of the judge to the personality of the plaintiff. This has not gone unremarked upon by the Courts, and as we will see in the discussion that follows, the High Court in *Rosenberg v Percival*<sup>70</sup> has expressed some concern about this aspect of the 'informed consent' decisions.

The remainder of this Chapter will involve an in depth analysis of the treatment of causation in 'informed consent' decisions. I have chosen to explore the judicial debates in some detail as they clearly demonstrate the difficulties that arise when the law attempts to establish a link between two different interests (the dignitary and the physical) - a link that is, quite simply, missing.

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<sup>66</sup> Ibid, [72] (Harrison J).

<sup>67</sup> Ibid, [6], [92] and [94].

<sup>68</sup> Ibid, [94].

<sup>69</sup> In *Bustos* and *Bergman* the plaintiff was searching for a perfection that could not possibly come from the procedure and in *Wallace* the plaintiff was intent from the outset on surgical intervention and ultimately, despite a complete lack of improvement, was not in any worse a position than he was prior to the treatment.

<sup>70</sup> (2001) 205 CLR 434.

### *The subjective approach in the High Court: Rosenberg v Percival*<sup>71</sup>

[7.50] *Rosenberg* represents an authoritative statement that the appropriate test for causation is subjective.<sup>72</sup> The decision also serves to demonstrate the manner in which the subjective test is tempered by evaluation of the plaintiff before the Court. Each of the judges noted that the primary judge did not warm to the respondent, describing his view of her evidence as ‘unconvincing,’<sup>73</sup> ‘unbelievable,’<sup>74</sup> ‘of no evidentiary value whatsoever,’<sup>75</sup> and ‘of no assistance in the circumstances,’<sup>76</sup> and it was held that she would have proceeded with the surgery despite her strong assertions to the contrary. Thus we have a decision about causation which purports to be subjective but depends upon a complete rejection of the subjective evidence of the plaintiff. At first glance this appears to represent a distinctive shift to an objective test, but close analysis of the decision will reveal a mix of subjective qualities of the plaintiff (including her pre-treatment knowledge and experience<sup>77</sup>) and objective factors (the central question being, what would a reasonable patient in this position have decided?). What we do not see, however, is an acknowledgement of the significance of the provision of advice and the empowerment of the patient when given that information. The focus is, once again, on the final stage of the decision-making process, the provision of consent and the manifestation of a physical harm. These questions are more suited to a trespass enquiry.

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<sup>71</sup> Two High Court decisions will be considered in some detail, *Rosenberg v Percival* (2001) 205 CLR 434 and *Chappel v Hart* (1998) 195 CLR 232, whilst *Chappel* clearly pre-dates *Rosenberg* I have chosen to discuss the later case first as it addresses the broad causation question. *Chappel* on the other hand is unusual as it deals with the complex question of the loss of a chance and raises some other issues which warrant specific attention, against the backdrop of the test as clarified in *Rosenberg*.

<sup>72</sup> *Rosenberg v Percival* (2001) 205 CLR 434, [24] (McHugh J), [87] (Gummow J), [157] (Kirby J), [216] (Callinan J). The *Rosenberg* test is also of continued relevance in those jurisdictions which, as noted above, specifically address the subjective nature of the causative test and prohibit plaintiff evidence of what they would have done. It has been argued, and I agree, that the legislative approach is a specific statement of the *Rosenberg* approach. This position will be clarified in the following discussion.

<sup>73</sup> *Ibid*, [15] (Gleeson CJ).

<sup>74</sup> *Ibid*, [28] (McHugh J).

<sup>75</sup> *Ibid*, [52] (Gummow J).

<sup>76</sup> *Ibid*, [126] (Kirby J), also note [127] and [161]. Callinan J also commented on the scepticism of the Trial J, at [198]. Thus the plaintiff here started from a similar position to that of plaintiff’s in the jurisdictions which prohibit plaintiff evidence. Indeed, it could be argued that her position was prejudiced by her evidence and apparent lack of credibility.

<sup>77</sup> Evidence permitted under the legislative regime.

## The facts and issues<sup>78</sup>

[7.60] The respondent, Dr Percival, was treated by Dr Rosenberg (an oral and maxillofacial surgeon) for a deteriorating malocclusion. There were a number of treatment options but she stressed that she 'wanted the best result.'<sup>79</sup> The selected treatment was orthognathic surgery, which involved surgical realignment of the jaw. It was accepted by all that there was no warning regarding risks of temperomandibular joint (TMJ) injury, and this was the precise category of injury which manifested after the surgery. Dr Percival suffered from persistent pain following the initial treatment and underwent some further surgery followed by physiotherapy, with disappointing results. At the time of trial, she continued to suffer from chronic pain and was unable to speak at full volume, she also experienced difficulty eating, suffered from muscle spasms and overall, had a reduced quality of life.

The original action was brought in the District Court of Western Australia and there were a number of issues before the Court, including the materiality of the information and causation.<sup>80</sup> It was in the District Court that Dr Percival came before Gunning J and failed to impress him as a credible witness. It was his comments regarding her credibility that perhaps formed the basis of a successful appeal to the Full Court of the Supreme Court of Western Australia.<sup>81</sup> The leading judgment was presented by Wallwork J who was clearly concerned about the trial judge's conclusions regarding the credibility of Dr Percival and found that he had failed to take certain, what he viewed as key, issues into account:

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<sup>78</sup> The facts as described here are a summary of the events as set out by Callinan J in his judgment [168]-[205]. All other Judges in the High Court referred to Callinan J's summation of facts.

<sup>79</sup> *Ibid*, [169] (Callinan J).

<sup>80</sup> For the purposes of this discussion it will be noted that it was accepted that she ought to have been warned of the risk of TMJ injury, the focus will be on the operation of the subjective test of causation.

<sup>81</sup> This conclusion is supported by Kirby and Callinan JJ in *Rosenberg v Percival* (2001) 205 CLR 434, [137] (Kirby J) and [199] (Callinan J).

The learned primary judge rejected the proposition that the appellant would have not had the surgery had she been warned of the possible risks. However, in my view the submission of the appellant's counsel that in coming to an adverse view of the appellant's credibility the learned primary judge did not take into account the important matter of the severe effects which the complications have had upon the appellant, both physically and mentally, is correct ... Counsel made the valid point that had the appellant been properly warned in the circumstances, she may not have been carrying the obvious depression, the chronic anxiety and the collapse of her career which had occurred. The appellant may not have been as prone to make alleged extravagant statements. As counsel submitted, the reasons for judgment should have identified and articulated the actual disabilities which the appellant had and attempted to dissect how they were contributing to her performance and behaviour.<sup>82</sup>

It was because of this apparent oversight that the Court of Appeal ordered a retrial on the question of causation. It is also worth asking the question, what difference would it have made if the patient either had been told of the risk or the true nature of the harm done to her (that is a denial of access to material information) acknowledged? Perhaps less emotional and psychological harm would have been suffered and, more significantly, perhaps less time would have been spent in the Courts. In short, if the Courts had been in a position to acknowledge a lack of informed choice instead of struggling with the notion of 'informed consent,' the judicial process and personal cost would have been significantly reduced.

This was not, however, the case, and working within the confines of the 'informed consent' doctrine, the argument was taken to the High Court. It was argued on behalf of Dr Rosenberg that the decision of the primary judge,

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<sup>82</sup> *Percival v Rosenberg* [1999] WASCA 31, [100]-[101] (Wallwork J).

‘based on credibility, must stand unless it is shown that the judge failed to use his advantage or acted on evidence which was inconsistent with facts incontrovertibly established or was glaringly improbable.’<sup>83</sup> It was further suggested that although the test is a subjective one, objective facts ‘must be called in aid’ to reach a determination of what the patient would or would not have done.<sup>84</sup> Interestingly, the argument in support of Dr Percival also appealed to objective elements, describing the test as ‘only nominally subjective’ with a need to look to ‘objective surroundings.’<sup>85</sup> Clearly, counsel for Dr Percival viewed the objective factors as being in her favour, the High Court did not agree.

### **The decision<sup>86</sup>**

[7.70] The decision in this instance rested primarily on the reluctance of the High Court, as an appellate Court, to overturn the decision of the primary judge, based upon individual assessment of plaintiff credibility.<sup>87</sup> Each of the presiding judges presented a detailed consideration of the application of the subjective test, the role of appellate Courts and the relevance of objective elements. Significantly, none of the judges was prepared to rest his conclusion on the purely subjective test and Gunning J’s opinion of the respondent, preferring instead to measure the subjective evidence against the objective facts. Thus we see the emergence of a hybrid test and it can be argued that, in adopting the external yardstick of objectivity, the High Court has moved away from the less certain ‘policy’ of the House of Lords towards a more transparent framework. A close analysis of the individual judgments will help to determine whether or not this is so.

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<sup>83</sup> *Rosenberg v Percival* (2001) 205 CLR 434, 434-435.

<sup>84</sup> *Ibid*, 435.

<sup>85</sup> *Ibid*, 436.

<sup>86</sup> The individual judgments all considered the different issues before the Court, the analysis here will however, focus only on the discussion relevant to causation.

<sup>87</sup> Although it must be noted that both Kirby and Callinan JJ expressed deep concern regarding the attitude of the primary judge to Dr Percival, this will be outlined in more detail below.



In the briefest of the judgments, Gleeson CJ chose the nature of the risk as his starting point. In a simple and persuasive discourse, he pointed out that in the ordinary conduct of life, we are surrounded by ‘adverse contingencies’<sup>88</sup> and it is only the more serious ones that give us pause and cause us to alter our decisions. If a risk appears to be remote, then it is unlikely to cause an individual to change course.<sup>89</sup> Of significance to His Honour was the remote nature of the risk<sup>90</sup> which was then viewed through the ‘prism of hindsight,’<sup>91</sup> with an elevated significance. It was the combination of these factors which enabled Gleeson CJ to look past any reservations he may have felt regarding the strong negative reaction of the Primary judge (to the plaintiff) as his ‘findings on the issue of causation did not depend solely upon the adverse opinion he formed.’<sup>92</sup> A sense of caution with respect to a simple application of the subjective test is apparent in this judgment. There is little reference to the assertions of Dr Percival that she would not have proceeded with treatment had she been warned. Rather, the foundation of Gleeson CJ’s conclusion with respect to causation was the nature of the risk combined with objective elements such as Dr Percival’s professional background, apparent lack of interest in risk and her need for corrective surgery.<sup>93</sup>

McHugh J endeavoured to highlight the significance of the subjective test yet found it necessary to set out the relevant objective factors in a detailed consideration of the balance between objective and subjective elements. His judgment began from the position that the test is a subjective one in Australia with the Court asking the question of what *this patient* would have done.<sup>94</sup> In his view, however, this is not the most important question:

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<sup>88</sup> *Rosenberg v Percival* (2001) 205 CLR 434, per Gleeson CJ [14].

<sup>89</sup> Gleeson CJ pointed out that the act of driving to a doctor’s surgery contains risk of injury in a car accident, but that will not stop the patient taking that risk which he described as „inconsequential“ [14].

<sup>90</sup> *Ibid.*, [15].

<sup>91</sup> *Ibid.*, [16].

<sup>92</sup> *Ibid.*, [17].

<sup>93</sup> *Ibid.*

<sup>94</sup> *Ibid.*, [24] (McHugh J).

What a reasonable person would or would not have done in the patient's circumstances will almost always be the most important factor in determining whether the Court will accept or reject the patient's evidence as to the course that the patient would have taken.<sup>95</sup>

Objective elements are therefore a method of assessing the evidence of the plaintiff. This position becomes confusing when considered in the context of the concluding comments of his judgment when he reiterated the law's commitment to a subjective test and noted that,

If the patient is believed, he or she succeeds even though the objective facts point the other way. If the evidence of the patient is rejected, he or she carries the heavy evidentiary burden of persuading the Court to make a favourable finding on the causation issue solely by reference to the objective facts and probabilities.<sup>96</sup>

The problem with this reasoning is that, as noted earlier in his judgment 'human nature being what it is, most persons who suffer harm as the result of a medical procedure and sue for damages genuinely believe that they would not have undertaken the procedure, if they had been warned of the risk of that harm.'<sup>97</sup> On this reasoning, every plaintiff comes to the Court and tells the truth as they see it. It is not the veracity of the plaintiff that is assessed against the objective factors; it is instead the *reasonableness* of their belief that is assessed by consideration of external factors, the implication being that this process takes place even if the patient is believed.<sup>98</sup> The plaintiff evidence is therefore of little import and, in a manner similar to that dictated by the

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<sup>95</sup> Ibid.

<sup>96</sup> Ibid, [44].

<sup>97</sup> Ibid, [26].

<sup>98</sup> Or to put it another way, the patient ought always be believed as they are presenting their version of reality and, are telling the truth as they know it. The question is whether that particular reality is reasonable.

legislative provisions, the 'matter is to be determined subjectively in the light of all relevant circumstances.'<sup>99</sup>

McHugh J himself went through such a measuring process when he noted that it was not simply the 'demeanour and personal attributes' of Dr Percival that resulted in a rejection of her evidence. It was the important interplay of objective factors.<sup>100</sup> He then listed these factors in some detail as including, *inter alia*, assessment of the patient's character and personality, the common nature of the procedure, the slight risk of harm and this procedure being the most likely to produce the best results.<sup>101</sup> The subjective test begins to look increasingly objective.

Gummow J adopted a similar approach to Gleeson CJ in that he noted the significance of the nature of the risk, highlighting the relevance not only of the degree of risk, but also the severity.<sup>102</sup> His approach to the test was relatively straightforward as he emphasised the importance of the primary judge's conclusions regarding the credibility of Dr Percival,<sup>103</sup> which he found were clearly supported by objective factors.<sup>104</sup> Once he reached this point in his reasoning, it was his position that there simply was no appealable error. Whilst this judgment was the most straightforward application of the subjective test involving a simple acceptance of the opinion of Gunning J, it must be recognised that the objective factors were still of relevance.

In his judgment, Kirby J strove to strike a balance between the need to adhere to a subjective test (which in his view is consistent with both the general principles of tort law and the rationale behind the imposition of a duty to

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<sup>99</sup> *Civil Liability Act 2002* (NSW) s5D(3)(a), *Civil Liability Act 2003* (Qld) s11(3)(a), *Civil Liability Act 2002* (Tas) s13(3)(a). The wording of *Civil Liability Act 2002* (WA) s5C(3) is different and refers to determining what 'the injured person would have done if the tortfeasor had not been at fault'.

<sup>100</sup> *Ibid*, [31].

<sup>101</sup> *Ibid*, [31]. These factors have been listed in detail here as they play a role in the reasoning of each of the judges.

<sup>102</sup> *Ibid*, [56] (Gummow J).

<sup>103</sup> *Ibid*, [50], [52] and [87].

<sup>104</sup> *Ibid*, [87]. The factors listed were similar to those outlined by McHugh J.

warn)<sup>105</sup> and any negative impact that the primary judge's strong adverse reaction to Dr Percival may have had. In endeavouring to attain equilibrium of interests, Kirby J was prepared to acknowledge the practical problems of implementation but felt that these problems did not provide sufficient reason to turn away from a subjective approach.<sup>106</sup>

The process adopted by Kirby J is an interesting one as he began with a clear statement of his reluctance to overturn the initial assessment of credibility made by the primary judge<sup>107</sup> but then expressed concern regarding this assessment. He commented that it was early in the judgment that the 'primary judge indicated his disbelief of [her] evidence'<sup>108</sup> and highlighted the emphasis that the judge placed on the fact that Dr Percival was 'most anxious to tell her story in a way in which she thought would benefit her case and to play down anything that she thought might be to the contrary.'<sup>109</sup> Kirby J also noted that the primary judge referred to her evidence as 'unreliable' and found that her assertions regarding what she would (or would not) have done were such as 'would be expected in the circumstances and of course, again in the circumstances, [is] of no evidentiary value whatsoever.'<sup>110</sup>

Kirby J was not receptive to the reasoning of Gunning J and was determined to look beyond his mere dislike of the respondent. He noted that the finding on causation was 'based on ... assessment of the credibility of the respondent'<sup>111</sup> and that the strong personal reaction of the primary judge may have influenced the actions of the Appeal Court in Western Australia, causing them to 'overreact'<sup>112</sup> and neglect the appropriate approach to causation. These clear observations of the trial process and subsequent

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<sup>105</sup> Ibid, [154] (Kirby J).

<sup>106</sup> Ibid, [155]-[157].

<sup>107</sup> Ibid, [125].

<sup>108</sup> Ibid, [126].

<sup>109</sup> Ibid, [127].

<sup>110</sup> Ibid, [129] (setting out the reasons of the primary judge).

<sup>111</sup> Ibid, [136].

<sup>112</sup> Ibid, [136] and [137].

appeal created an excellent foundation for a reasoned consideration of the facts and the application of the relevant test. He emphasised the role of the subjective test, noting the problems with its implementation.<sup>113</sup> Despite these concerns, however, Kirby J categorically stated that the Court should not adopt a variant of the objective test as it would be inconsistent with the requirements of *Rogers*,<sup>114</sup> preferring instead to rely on subjective factors. It is interesting to note that despite the strong assertion of a subjective test, His Honour, in seeking to put to rest his concerns regarding some of the comments of Gunning J, referred to (and highlighted) the external factors which supported the initial determination on causation. Indeed, Kirby J took the conclusions one step further and suggested that when one took into account the objective factors that also supported Gunning J's assessment of the evidence, it became clear that in practical terms, and 'as a matter of inherent probabilities and logic,' both objective and subjective tests would have resulted in the same outcome.<sup>115</sup>

Of all of the judges, Callinan J expressed the most concern regarding the approach adopted by Gunning J. He began by noting his strong negative reaction which led to scepticism and outright rejection of the respondent's evidence.<sup>116</sup> He agreed with Kirby J's assessment of the Appeal Court's decision as being overly influenced by this negative response, referring to the 'unduly critical' nature of the initial judgment.<sup>117</sup> Underlying Callinan J's evident discomfort with the conduct of the trial and subsequent treatment of the case by the Supreme Court was the fact that, unlike Kirby and McHugh JJ, he was not prepared to embrace the subjective test as the most appropriate.

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<sup>113</sup> Ibid, [155].

<sup>114</sup> Ibid, [157].

<sup>115</sup> Ibid, [165].

<sup>116</sup> Ibid, [198], (Callinan J).

<sup>117</sup> Ibid, [199] and [222].

He expressed reservations regarding the relevance of plaintiff evidence and noted that,

there is, in my opinion, a real doubt, whether a negative answer to a question, 'Would you have had the operation?', artificially posed, years after the event, and answered, almost certainly, after the patient has suffered unexpected complications, and after repeated innocent rehearsal in making a statement and in conference with legal advisors, can ordinarily carry much conviction, or should provide the basis for an undiscounted award of damages, or indeed, damages at all. A disinterested bystander might well say of such an answer, 'Of course, naturally she (or he) would say that.'<sup>118</sup>

It is perhaps this view, in taking the concerns highlighted by some of the other judges a step further, which resulted in his strong conclusion that the primary judge was 'unduly critical of the respondent'<sup>119</sup> and was sufficient to give him 'serious pause in this case.'<sup>120</sup> Despite His Honour's close consideration of the problems with the manner in which the case had been dealt with and evident discomfort with the treatment of the respondent, he was able to quickly and effectively deal with them. In a brief statement he noted that despite such strong concerns, the 'judge's conclusion as to the incredibility of Dr Percival's answer that she would 'never' have had the operations must be accepted.'<sup>121</sup> How could such deep concerns be dealt with so efficiently? By simple reference to the objective factors.

In summary, therefore, Gleeson CJ treated the subjective elements with caution, choosing to emphasise the objective ones. This caution was extended by Callinan J who expressed deep reservations regarding the subjective elements, preferring instead to find a straightforward solution in the objective

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<sup>118</sup> Ibid, [214].

<sup>119</sup> Ibid, [222].

<sup>120</sup> Ibid, [223].

<sup>121</sup> Ibid, [223].

elements. A different approach was adopted by McHugh J who emphasised the nature of the test but insisted that the objective factors be considered in detail as, in his view, it is these factors that allow the Court to determine whether or not the plaintiff is telling the truth. Indeed he took this further by suggesting that the outcome of both objective and subjective tests would be the same.<sup>122</sup> A similar conclusion was reached by Kirby J who was prepared to recognise the practical difficulties of the subjective test, but asserted that it is the only appropriate test as it is consistent with the essence of negligence law. It is interesting to note, however, that in reaching his final conclusion, he referred to the objective elements. Finally, Gummow J's judgment represented the strongest adherence to the subjective test but he still turned to objective factors to validate his conclusion. One cannot therefore conclude that the test for causation in Australia is a straightforward subjective one. Whilst the High Court prefers to label it as subjective there is clear reliance on objective factors. The test is one which begins with subjective elements and moves on to test them against objective criteria, and is best described as a hybrid test.

What is the end result? It is a situation in which it is most likely that both objective and subjective tests would have resulted in the same outcome.<sup>123</sup> Why then the ongoing debate? Perhaps it is simply indicative of the problematic nature of the process which requires a conceptual shift from the dignitary interest in the receipt of information (which is the focus of the breach enquiry) to the trespassory question of whether or not a plaintiff would have consented to treatment. Here we see the judges struggling with the 'marriage of two doctrines'<sup>124</sup> and finding that perhaps it is an unhappy marriage. The nature of the struggle and the mismatch of ideas was made

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<sup>122</sup> Ibid, [34] (McHugh J).

<sup>123</sup> Ibid, [165] (Kirby J).

<sup>124</sup> D.Beyleveld and R.Brownsword, *Consent and the Law* (Hart Publishing, Portland Oregon, 2007), 174. Discussed in Chapter 1,

A joining of two concepts (at [1.60]).

very clear in the earlier decision of *Chappel v Hart*<sup>125</sup> and subsequent decisions which seek to make sense of it.

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<sup>125</sup> (1998) 195 CLR 232.



## *Manipulating causation: Chappel v Hart*<sup>126</sup>

[7.80] *Chappel v Hart* has generated much scholarly debate and been described as both an appropriate manipulation of causative principles<sup>127</sup> and ‘a lost opportunity.’<sup>128</sup> Whatever view is adopted, the significance of this decision cannot be denied.<sup>129</sup> As we have seen, causation represents one of the most significant obstacles to a successful claim in negligent advice and it has been suggested that the existence of five separate judgments in *Chappel* stands as testament to the complexities of this area.<sup>130</sup> The issues before the Court were not easy, and, like *Chester* in the United Kingdom, challenged the Court ‘to give legal sanction to an underlying moral responsibility,<sup>131</sup> and required an elastic application of causative principles. When the case went before the High Court, there was a sense of anticipation and belief that it provided an opportunity to lend clarity to the discussion and provide clear guidance to lower Courts.<sup>132</sup> Unfortunately, however, these expectations were not met and whilst *Chappel* answered some questions, it left many more open.

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<sup>126</sup> (1998) 195 CLR 232. This decision deals with, *inter alia*, the question of a loss of a chance. In 2010 the High Court revisited the issue of a loss of a chance in *Tabet v Gett* (2010) 240 CLR 537. This decision will not, however, be discussed in this thesis as it is very clearly confined to the provision of medical treatment and the issue of pre-treatment advice is not raised.

<sup>127</sup> A. Honoré, „Medical Non-Disclosure, Causation and risk: *Chappel v Hart*“ (1999) 7 *Torts Law Journal* 1, 19-20. Honoré argues that this is a case where the „Courts are entitled to see that justice is done despite the absence of a causal connection.

<sup>128</sup> J. Clarke, „Causation in *Chappel v Hart*: Common Sense or Coincidence?“ (1999) 6 *Journal of Law and Medicine* 335, 347. Clarke suggests that the decision could have „resolved the problems with the law of causation“ and describes the decision as „disappointing“ (347). He also refers us to J. Lavery „*Chappel v Hart*: The High Court’s Lost Chance“ (1998) 7 (3) *Australian Health Law Bulletin* 25.

<sup>129</sup> Indeed, the reasoning in *Chappel v Hart* provided the foundation for much of the discussion in *Chester v Afshar* [2005] 1 AC 134: [9] (Lord Bingham), [21]-[23] (Lord Steyn), [93]-[95] and [99] (Lord Walker) and Lord Hope provides a complex consideration [64]-[88].

<sup>130</sup> Clarke, above n.128, 335. Also note M. Stauch, „Taking the Consequences for Failure to Warn of Medical Risks,“ (2000) 63 *The Modern Law Review* 261, and A. Honoré, above n.127 which refer to the complexities of causation in this context.

<sup>131</sup> A. Honoré, above n.127, 21.

<sup>132</sup> Refer D. Mendelson, „The Breach of the Medical Duty to Warn and Causation: *Chappel v Hart* and the Necessity to Reconsider Some Aspects of *Rogers v Whitaker*‘ (1998) 5 *Journal of Law and Medicine* 312, 318 where the author hopes that the High Court will take the opportunity to balance the protection of individual patients and those of the community in having a viable medical profession. This is taken one step further in, J. Devereux, „It’s Just a Jump to the Left – and then a Step to the Right: Developments post *Rogers v Whitaker* in the Law Relating to Failure by a Medical Practitioner to Advise of Risks“ (1998) 17 *University of Tasmania Law Review* 63, when the author argues that the High Court should reject the Court of Appeal decision on the basis that it is „bad law“ and does not provide for consistency in the law of negligence, 78-79.

## The facts and issues

[7.90] Mrs Hart sought treatment for a pharyngeal pouch: an extremely uncomfortable condition which meant that food could become caught in her throat. The operation to remove the pouch was performed (without negligence) by Dr Chappel. Unfortunately, during the operation her oesophagus was perforated, an infection (mediastinitis) set in and she suffered long-term damage to her voice. The basis of her claim was that whilst Dr Chappel had warned her of the slight risk of perforation, he had ignored her concerns regarding long-term damage to her voice,<sup>133</sup> and failed to warn her of the chance of infection and long-term injury.

If Dr Chappel had warned Mrs Hart of this risk, it was accepted that she would have delayed treatment and sought a more qualified and experienced surgeon. There was no doubt that she would have eventually undergone the same procedure as her condition was 'relentlessly progressive'<sup>134</sup> and surgical intervention was the only form of relief available.<sup>135</sup> It was also common ground that,

... the aetiology of the damage to Mrs Hart's laryngeal nerve was not in doubt. It required the coincidence of three events: (1) the operative tear to the oesophagus; (2) an escape of bacteria from the oesophagus; and (3) consequential impingement of the resulting infection upon the nearby right vocal cord causing paralysis and damage. Each of these preconditions was accepted to be very rare.<sup>136</sup>

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<sup>133</sup> Mrs Hart's evidence was that she had expressed specific concerns and had stated that she did not „want to wind up like Neville Wran.“ Neville Wran was a past Premier of New South Wales who had suffered widely publicised injury to his voice, her reference therefore indicated a concern regarding the possible impact on her voice.

<sup>134</sup> This key fact was accepted by the Court, see *Chappel v Hart* (1998) 195 CLR 232, [2] (Gaudron J), [38] (McHugh J), [91] (Kirby J) and [110] (Hayne J).

<sup>135</sup> Indeed, she had a subsequent operation to remove a grape which had become lodged in her throat, *Chappel v Hart* (1998) 195 CLR 232, [104] (Hayne J).

<sup>136</sup> *Ibid*, [91] (Kirby J).

There was clear consensus regarding both the duty to warn and the key facts of the case. The decision turned on the issue of causation and the split between the majority and minority judgments rested on the significant question of whether or not the failure to warn made a difference to the chance of the injury manifesting.<sup>137</sup>

### The decision<sup>138</sup>

[7.100] Earlier in Part II the significance of policy was recognised and demonstrated through the discussion of *Chester*.<sup>139</sup> In contrast to the House of Lords, the High Court in *Chappel* tended to avoid the language of policy,<sup>140</sup> preferring instead to adopt the ‘common sense’ test developed in *March v Stramare*.<sup>141</sup> Similarly to *Chester*, however, both the majority and minority judges relied upon the same test to arrive at different conclusions, thereby exposing possible limitations of the test. The use of the common sense test in this context has attracted some criticism, with it being described as ‘recognition that resolving issues of causation in legal contexts may require value judgments,’<sup>142</sup> ‘not very satisfactory,’<sup>143</sup> ‘uncertain,’<sup>144</sup> ‘a leap of logic’<sup>145</sup> and ‘worrying indeed.’<sup>146</sup> The only certainty with the ‘common sense’ test is that, like policy, it depends upon who is applying it and in what

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<sup>137</sup> There is another strand of contention surrounding this decision which centres around the possibility of a successful loss of a chance action. This is beyond the ambit of the current discussion, but it was clearly rejected by the Court, see *Chappel v Hart* (1998) 195 CLR 232, [50]ff (McHugh J) [135]ff (Hayne J), [70] and [76] (Gummow J) [100] (Kirby J) and refer Gaudron J in general. For further consideration of the issue of loss a chance refer *Tabet v Gett* (2010) 240 CLR 537.

<sup>138</sup> In this section, the focus will be on the specific approach of each of the judges. There is a further issue regarding reversal of the evidential onus which emerged from this decision, and this will be considered below.

<sup>139</sup> *Chester v Afshar* [2005] 1 AC 134, see discussion in Chapter 6, Manipulating causation: *Chester v Afshar* (at [6.70]).

<sup>140</sup> Although McHugh J did make reference to policy considerations in the context of ‘common sense.’ *Chappel v Hart* (1998) 195 CLR 232, [24].

<sup>141</sup> *March v Stramare* (1991) 171 CLR 506. It was in this decision that the High Court clearly rejected the ‘but for’ test as the determinative test of causation.

<sup>142</sup> P. Cane, ‘A Warning About Causation’ (1999) 115 *Law Quarterly Review* 21, 26.

<sup>143</sup> S.M. Waddams ‘Causation, Physicians and Disclosure of Risks’, ‘Causation, Physicians and Disclosure of Risks’ [1999] 7 *Tort Law Review* 5, 5-6.

<sup>144</sup> B. Milstein, ‘Causation in Medical Negligence – Recent Developments’ (1997) 6 *Australian Health Law Bulletin* 21, 22.

<sup>145</sup> D. Mendelson, ‘Liability for Negligent Failure to Disclose Medical Risk,’ (2001) *Journal of Law and Medicine* 358, 365.

<sup>146</sup> Clarke, above n.128, 347.

context. 'Common sense' led McHugh and Hayne JJ to the conclusion that the failure to warn did not have a causal link with the injury suffered whilst Gummow, Gaudron and Kirby JJ found that common sense took them in the opposite direction. From Dr Chappel's perspective, one cannot help but conclude that the outcome is neither common nor sensible.

It is in the minority judgments that the strictest adherence to a clear causal chain can be found thus it is those judgments that I will consider first. I have chosen this approach because the dissenters provide the most coherent approach to the law, the majority on the other hand, seek to do 'justice' with tools that are not up to the task. To begin with McHugh J, His Honour opened with a consideration of basic causal principles. It was his unequivocal position that the breach of duty and injury suffered must be 'relevantly connected' with 'common sense ideas' determining what makes a connection 'relevant' in a legal sense.<sup>147</sup> It is important to recognise that McHugh J readily accepted that Dr Chappel's failure to warn Mrs Hart of the risk of long-term damage to her voice was 'one of the events that in combination with others led to ... the damage' and that 'statistically the chance of it occurring during an operation on another occasion was very small.'<sup>148</sup> Such a link was not, however, sufficient to create the requisite 'relevant connection,' consistent with the rejection of the 'but for' test in *March v Stramare*, something more was required.<sup>149</sup>

McHugh J placed emphasis on the essence of causation as the 'allocation of responsibility for harm or damage'<sup>150</sup> with the key to responsibility being a material contribution to the suffering of the harm.<sup>151</sup> In focusing on the notion of responsibility and rejection of the 'but for' enquiry as a

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<sup>147</sup> *Chappel v Hart* (1998) 195 CLR 232, [23] (McHugh J).

<sup>148</sup> *Ibid*, [25].

<sup>149</sup> It is important to note at this point, that his rationale in this stage of the discussion was in accord with that of the majority.

<sup>150</sup> *Ibid*, [26].

<sup>151</sup> *Ibid*, [27].

determinative one, McHugh J noted that something more than a coincidence of time and place is required and,

the fact that the risk eventuated at a particular time or place by reason of the conduct of the defendant does not itself materially contribute to the plaintiff's injury unless the fact of that particular time or place increased the risk of the injury occurring.<sup>152</sup>

Once he had set out the basic premise of causation, McHugh J turned his attention to the evidence before the Court. He carefully explored the nature of Mrs Hart's condition<sup>153</sup> and the suggestion that a more experienced surgeon would have reduced the risk of perforation and infection. In his view, to conclude that the failure to warn Mrs Hart caused the injury would 'seem an affront to common sense.'<sup>154</sup> An application of common sense to the facts lead McHugh J to the conclusion that the 'cause of the perforation and the consequent mediastinitis was the examination of the oesophagus with a rigid endoscope, an examination which carried with it an inherent risk of perforation.'<sup>155</sup> The lack of advice was little more than a coincidence and did not materially contribute to the injury. The fatal flaw then was the absence of a link between the failure to inform and the manifestation of the physical harm. If the harm itself had been re-defined to be a loss of choice, then the link would have been clear and unproblematic.

A slightly different approach was adopted by Hayne J who began from the facts of the case and moved into application of the principles of negligence to these facts. In applying common sense to the facts before him, Hayne J, like McHugh J, concluded that the failure to warn did not cause the injury

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<sup>152</sup> Ibid.

<sup>153</sup> „Relentlessly progressive“, [38].

<sup>154</sup> Ibid, [43]. He reached this conclusion by applying the rationale to an alternate fact scenario in which Dr Chappel did warn Mrs Hart and she sought out another surgeon who subsequently perforated the oesophagus and mediastinitis developed. To so conclude would be a faithful adherence to the „but for“ test and an extension of the rationale leading to liability of Dr Chappel for Mrs Hart's present injury.

<sup>155</sup> Ibid.

suffered by Mrs Hart.<sup>156</sup> His Honour directed attention to certain ‘features of the case’ which, in his view, needed to be born ‘steadily in mind.’<sup>157</sup> These key factors included recognition that the breach of duty rested in the failure to warn and that the procedure was conducted without negligence. He accepted that the condition was ‘relentlessly progressive’ and required surgery, therefore the situation was one of delay as opposed to cancellation. He noted that ‘whilst perforation of the oesophagus was not uncommon’ the mediastinitis was ‘very rare.’ Finally, Mrs Hart had been ‘accepted as a witness of truth’ and therefore the decision was based on the fact that she would have sought further advice and requested that the surgery be performed by ‘the most experienced person with a record and reputation in the field.’<sup>158</sup>

Hayne J considered the ‘but for’ test, and recognised its utility as a preliminary enquiry and a ‘negative test ... if it is not satisfied, it is unlikely that there is the necessary causal connection,’<sup>159</sup> but rejected it as the exclusive test. His Honour emphasised the need for a conclusion based upon careful reasoning and cautioned against a conclusion ‘without any lengthy articulation of reasons,’<sup>160</sup> and then concluded:

In my view the only connection between the failure to warn and the harm the respondent has suffered is that but for the failure to warn she would not have been in harm’s way ... The appellant’s conduct did not affect whether there would be pathogens present in the respondent’s oesophagus, when the procedure was carried out; his conduct did not affect whether the pathogens that were present would, in all the circumstances, produce the infection which they did;

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<sup>156</sup> Once again being limited by a physical definition of the injury.

<sup>157</sup> Ibid, [110] (Hayne J).

<sup>158</sup> Ibid.

<sup>159</sup> Ibid, [117] (Hayne J). This preliminary stage of the enquiry was later endorsed in *Rosenberg v Percival* (2001) 205 CLR 434 and as we have seen, has since been enshrined in statute.

<sup>160</sup> Ibid, [111] (Hayne J).

his conduct did not affect whether that infection would damage the laryngeal nerve as it did.<sup>161</sup>

His Honour then moved on to a clear statement of principle which indicated that his (and indeed McHugh J's before him) approach accorded with core principles of negligence. He accepted that the purpose of a duty can inform the causation enquiry,<sup>162</sup> but cautioned that it cannot 'obscure the fact that the search is for a relationship between the negligent act ... and the damage.'<sup>163</sup> The importance of autonomy was recognised by Hayne J, as was the relevance of the connection between the risk which was both the subject of the duty to warn and the injury which manifested. But in drawing the enquiry back to basic causal principles, he emphasised that a mere connection is not sufficient there must be a clear and direct link.<sup>164</sup> Once again we see that if the harm had been re-defined to include the denial of personal authority, then the link would have been clear.

Both of the minority judges relied upon their interpretation of the facts and their decision turned on the failure, in their view, to demonstrate that the surgeon's skill had an 'effect on the unusual chain of events.'<sup>165</sup> Both McHugh J and Hayne J appealed to basic causal principles, rejected the but for test as determinative and employed the language of 'common sense.' As will be seen, this approach is not materially different from that of the majority; the difference lies in the individual interpretation of what 'common sense' means. It is my position that the adoption of 'common sense' in this decision is similar to that of 'policy' in *Chester v Afshar*, a linguistic nicety that covers individual notions of what is the 'right' answer in the circumstances.<sup>166</sup>

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<sup>161</sup> Ibid, [121] (Hayne J).

<sup>162</sup> Referring to the key judgment of Lord Hoffman in *Environment Agency v Empress Car Co (Abertillery) Ltd* [1999] 2 AC 22 which referred to the impact of the purpose of the duty. This approach was to prove influential in *Chester v Afshar* [2005] 1 AC 134 and in some of the majority judgments in the present decision.

<sup>163</sup> *Chappel v Hart* (1998) 195 CLR 232, [122] (Hayne J).

<sup>164</sup> Ibid, [123]-[124], (Hayne J).

<sup>165</sup> Ibid, [133] (Hayne J).

<sup>166</sup> This will be explored further in Chapter 9: The Policy Diversion (at [9.20]ff).

In a judgment appealing to notions of justice, Gummow J placed emphasis on the nature and significance of the injury. He acknowledged that the central issue was one of causation and noted that since *March v Stramare*<sup>167</sup> the 'but for' test is no longer definitive.<sup>168</sup> It was in his search for what constitutes that 'something more' that we see a clear divergence from the minority.

Gummow J began from the purpose of the duty which he described as the 'right of the patient to know of material risks'<sup>169</sup> and then moved on to a consideration of the nature of the risk of injury and its potential impact on Mrs Hart. Of significance to him was the enquiry made by Mrs Hart combined with the specific impact of a loss of voice on her lifestyle. He highlighted the fact that not only ought she to have been warned of this risk but she had specifically asked about it. Furthermore, she was a person 'for whom the potential damage to her voice was more significant than the 'statistical' risk.'<sup>170</sup> In his view, it was the combination of these factors, 'combined with the satisfaction of the 'but for' test [that] were sufficient to establish causation in this case.'<sup>171</sup>

It is appropriate here to re-visit the *Rogers v Whitaker* materiality test:

a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risks would be likely to attach significance to it.<sup>172</sup>

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<sup>167</sup> (1991) 171 CLR 506.

<sup>168</sup> *Chappel v Hart* (1998) 195 CLR 232, [59] ff (Gummow J).

<sup>169</sup> *Ibid*, [65].

<sup>170</sup> *Ibid*, [66]-[67].

<sup>171</sup> *Ibid*, [67].

<sup>172</sup> (1992) 175 CLR 479, at 490.



The causative reasoning of Gummow J echoes this duty rationale. It was his position that Mrs Hart viewed any risk to her voice as material and this was evidenced (as with Mrs Whitaker before her), by her specific concerns. This evidence is relevant to a determination of duty to warn. To extend it to a conclusion of causation, I would suggest, is merging the duty and causation enquiries and overlooking the fundamental chain of causation.

Kirby J presented a reasoned judgment which acknowledged the complexities of the causative enquiry<sup>173</sup> at the same time as emphasising the important role of the High Court in the provision of guidance 'as to the approach to be taken when problems of this kind arise in the future.'<sup>174</sup> An interesting aspect of this particular judgment is the fact that Kirby J openly and candidly embraced the importance of value judgments and policy considerations,<sup>175</sup> thus acknowledging the underlying rationale of his (and other members of the Court) decision.

Kirby J approached the key issue of causation from a slightly different perspective than the other judges, pointing not to the purpose of the duty but to the purpose of causation.<sup>176</sup> He began with an acknowledgment of how difficult it is to establish causation<sup>177</sup> and moved on to critique this. He noted that such a complex process can (and does)

... cause dissatisfaction to litigants , anguish for their advisers, uncertainty for judges, agitation amongst commentators and friction between healthcare professionals and their legal counterparts.<sup>178</sup>

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<sup>173</sup> Ibid, [96] (Kirby J).

<sup>174</sup> Ibid, [88].

<sup>175</sup> Ibid, [93] (3).

<sup>176</sup> Ibid, [93](1).

<sup>177</sup> Ibid, [87].

<sup>178</sup> Ibid.

Whilst he was prepared to acknowledge the difficulties with the process, he could not move away from it and his decision was clearly guided by basic causal principles (as he viewed them).

In moving on to a consideration of the purpose of the causative enquiry, Kirby J emphasised that it is 'not to engage in philosophical debate,' rather it is 'about attributing responsibility.'<sup>179</sup> This position supports conclusions driven by what 'ought' to be done, and what outcome would be the 'just' one<sup>180</sup> but does not necessarily clarify or lend certainty to the decision. The process was muddied even further by Kirby J's acceptance that because causation is 'a question of fact' to be 'resolved as a matter of commonsense ... there is usually a large element of intuition in deciding such questions.'<sup>181</sup> The solution then becomes driven by personal perspectives and interpretations and in this instance, in direct contrast to the minority, Kirby J's intuition led him to the conclusion that 'the higher the skill of the surgeon, the less is the risk of any perforation of the oesophagus into the mediastinum.'<sup>182</sup> Thus because the possibility of harm was increased, causation was established. It is unclear how this application of 'intuition' to balance possibilities and probabilities provides the essential 'guidance to the approach to be taken when problems of this kind arise in the future.'<sup>183</sup> Open acknowledgment of the dignitary harm to Mrs Hart, however, would have provided the requisite clear guidance.

Gaudron J reached a similar, fact-driven conclusion to Kirby J. In a decision which turned on her interpretation of the evidence, Gaudron J was unable to accept the proposition that the timing of the surgery made no difference to the outcome. Whilst she readily accepted that a later surgery 'would have

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<sup>179</sup> Ibid, [93] (1).

<sup>180</sup> Refer Gummow J above and the majority of the Law Lords in *Chester v Afshar* [2005] 1 AC 134.

<sup>181</sup> *Chappel v Hart* (1998) 195 CLR 232, [93](2) (Kirby J).

<sup>182</sup> Ibid, [97].

<sup>183</sup> Ibid, [88].

been subject to the risk that eventuated' it would not, in her view, have been 'to the same degree.'<sup>184</sup>

Of all of the judges, Gaudron J gave the most considered response to Dr Chappel's argument that the injury 'was not physical but amounted to the loss of a chance.'<sup>185</sup> Whilst she was prepared to consider the position, she unequivocally rejected it, and it was this rejection that formed the basis of her conclusions. It was her position that if Dr Chappel's argument was accepted, then the risk would have been the lost opportunity and if this was the case, then 'the duty would have been a duty to inform her that there were more experienced surgeons practicing in the field.'<sup>186</sup>

The nature of the risk combined with the rarity of the condition to satisfy the causation test. The rationale employed by Gaudron J was similar to that of Gummow J as she reasoned that because the risk was 'both rare and random' it was 'preclude[d] from being described as other than speculative.'<sup>187</sup> The conclusion from this was, quite simply, that it would not have happened at another time. The traditional causative enquiry is absent from the reasoning of Gaudron J. She did note that 'questions of causation are not answered in a legal vacuum.'<sup>188</sup> Rather, according to Her Honour, tests of causation are to be considered in the broader context, or 'framework in which they arise.'<sup>189</sup> And it is this framework that remained the focus of Gaudron J's reasoning, with the physical nature of the risk driving her conclusion.

*Chappel v Hart*<sup>190</sup> is therefore a complex decision. Despite Kirby J's assertion that 'this Court must endeavour to give guidance in this case as to the

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<sup>184</sup> Ibid, [2] (Gaudron J).

<sup>185</sup> Ibid, [5].

<sup>186</sup> Ibid, [10].

<sup>187</sup> Ibid, [20].

<sup>188</sup> Ibid, [7].

<sup>189</sup> Ibid.

<sup>190</sup> (1998) 195 CLR 232.

approach to be taken when problems of this kind arise in the future,<sup>191</sup> it failed to clarify the causation issue. Each of the High Court judges acknowledged that the enquiry was to be driven by 'common sense,' but 'common sense' in the High Court, like 'policy' in the House of Lords does not provide a consistent legal framework and serves to allow individual perceptions to drive conclusions that claim to be driven by fact.

### **Muddying the waters: A presumption of causation?**

[7.110] Despite the clear endeavours of the individual judges in both *Rosenberg* and *Chappel* to identify the process of determining causation in the context of medical advice, it continues to be an 'area of the law that is highly discretionary and unpredictable.'<sup>192</sup> In the context of pre-treatment advice, most of the debate has focussed on the nature of the test (subjective or objective). But *Chappel v Hart* served to introduce a further layer of complexity when the judges hinted at a possible shift in evidentiary onus (from the plaintiff to the defendant) and thus a presumption of causation once breach of duty has been identified. This shift has provided impetus for lower Courts to neatly sidestep evidentiary gaps relating to causation and has been described as 'surprising'<sup>193</sup> and as representing 'a fundamental change in the traditional law about causation and proof of causation.'<sup>194</sup> Perhaps in a response to this, evidentiary onus has been specifically considered in recent legislative amendments,<sup>195</sup> but this does not signal the end of the debate.

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<sup>191</sup> Ibid, [88] (Kirby J).

<sup>192</sup> *Chappel v Hart* (1998) 195 CLR 232, [87] Kirby J (citing Honoré, *Causation and Remoteness of Damage, an International Encyclopedia of Comparative Law XI* (1983) Chapter 7, s105).

<sup>193</sup> E. Neilson, „*Chappel v Hart* (1998) 195 CLR 232: The problem with the common sense test of causation,“ (1999) 20 *University of Queensland Law Review* 318, 318.

<sup>194</sup> Ipp D.A., Cane P, Sheldon D, Macintosh I, „Final Review of the Law of Negligence,“ Treasury Department, Commonwealth of Australia, October 2002. („The Ipp Report“), [7.36].

<sup>195</sup> *Civil Law (Wrongs) Act 2002* (ACT), s46, *Civil Liability Act 2002* (NSW), s5E, *Civil Liability Act 2003* (Qld), s12, *Civil Liability Act 1936* (SA) s35, *Civil Liability Act 2002* (Tas), s14, *Wrongs Act 1958* (Vic), s52 and *Civil Liability Act 2002* (WA), s5 all provide that the plaintiff bears the burden of proving any fact relevant to causation.

The recent decision of *Jovanovski v Billbergia*<sup>196</sup> which applied the relevant legislation<sup>197</sup> once again raised the question of a presumption of causation. Davies J clearly stated that ‘certainly the onus remains on the plaintiff to prove causation’,<sup>198</sup> but in applying this test distinguished the facts before the Court<sup>199</sup> from those in both *Chappel v Hart*<sup>200</sup> and *Elbourne v Gibbs*<sup>201</sup> and stated that ‘the question is the extent to which inferences are available of a causal connection once it is shown there is a breach of duty to warn of a risk.’<sup>202</sup> Thus the existence of an inference of causation remains open and whilst the High Court has acknowledged the confused state of affairs and raised the question of the possibility of such an inference,<sup>203</sup> no answer was given. Thus in the absence of authoritative clarification the debate regarding a shifting of evidential onus must be considered here when we are attempting to unravel the complicated threads of the causation debate.

#### *The shifting onus in Chappel v Hart*<sup>204</sup>

[7.120] That Dr Chappel ought to have acknowledged Mrs Hart’s concerns and warned her of the risk to her voice was clear. Whether or not this made a difference to the outcome was, as demonstrated in the preceding discussion, not so clear. It has been suggested that with the ‘commonsense’ approach sitting so firmly in the realm of intuition, the Judges have been left in the uncomfortable position of intuitively believing that Mrs Hart ought to recover and then having to create a path of reasoning backwards to reach the

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<sup>196</sup> *Jovanovski v Billbergia Pty Ltd* [2010] NSWSC 211.

<sup>197</sup> *Civil Liability Act 2002* (NSW) s5D.

<sup>198</sup> *Ibid*, [67].

<sup>199</sup> The case was concerned with a workplace accident and the scope of an employer’s duty of care.

<sup>200</sup> (1998) 195 CLR 232.

<sup>201</sup> [2006] NSWCA 127, to be considered below.

<sup>202</sup> *Jovanovski v Billbergia Pty Ltd* [2010] NSWSC 211, [68] (Davies J).

<sup>203</sup> In denying Special Leave to an appeal from *Zaltron v Raptis* [2001] SASC 209 (24 July 2001), Gaudron J noted that there was a difference of opinion with respect to the evidential onus in *Chappel v Hart* (1998) 195 CLR 232, but stated that it was not an appropriate vehicle to solve that difference and Kirby J mentioned the „verbal formulae“ but declined to pursue it further because the decision had been made on a factual basis, *Zaltron v Raptis* A29/2001 (19 April 2002).

<sup>204</sup> (1998) 195 CLR 232. The more recent decision of *Naxakis v Western General Hospital* (1999) 197 CLR 269 is also cited as authority for this shift. It is however in the context of medical treatment and therefore outside of the scope of the current discussion.

perceived appropriate outcome.<sup>205</sup> This ‘backwards path’ was facilitated by the apparent reversal of the evidential onus.

Four of the members of the Court<sup>206</sup> supported the shift of evidentiary onus from plaintiff to defendant, once duty and breach have been established. Hayne J however, was emphatic in his rejection of such a shift, asserting that a mere link between the ‘subject matter of the negligent conduct’ and the ‘subject matter of the damage,’ was not enough.<sup>207</sup> A consideration of the process of shifting evidential onus demonstrates that in the view of the other judges, this link is not only significant but could prove to be decisive.

Gaudron J appeared to unquestioningly embrace the concept of an inference of causation once breach is established when she noted that,

The duty was called into existence because of the foreseeability of that very risk. The duty was not performed and the risk eventuated. Subject to a further question in the case of a duty to provide information, that is often the beginning and the end of the inquiry whether breach of duty materially caused or contributed to the harm suffered.<sup>208</sup>

She went on to discuss the ‘inference’ of causation that arises from the establishment of duty and breach<sup>209</sup> but also emphasised the significance of the plaintiff’s evidence as to what he or she would or would not have done if the information had been provided.<sup>210</sup> Thus in Her Honour’s view there was a mix of inference and plaintiff evidence rather than a shift of evidential onus to the defendant.

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<sup>205</sup> Neilson, above n.193, p322. Perhaps what they were „intuitively“ seeing was not her „loss of a chance“ but her denial of informed choice?

<sup>206</sup> Gaudron, McHugh, Gummow, and Kirby JJ.

<sup>207</sup> *Chappel v Hart* (1998) 195 CLR 232, [124] (Hayne J).

<sup>208</sup> *Ibid*, [8] (Gaudron J).

<sup>209</sup> The cited source of this inference is *Betts v Whittingslowe* (1945) 71 CLR 637.

<sup>210</sup> *Chappel v Hart* (1998) 195 CLR 232, [9] (Gaudron J).

McHugh J avoided the terminology of presumption or inference and referred instead to a *prima facie* case,

However, once the plaintiff proves that the defendant breached a duty to warn of a risk and that the risk eventuated and caused harm to the plaintiff, the plaintiff has made out a *prima facie* case of causal connection. An evidentiary onus then rests on the defendant to point to other evidence suggesting that no causal connection exists.<sup>211</sup>

From this position he moved on to a consideration of the type of evidence required of the defendant. However, he too immediately shifted focus to that of the evidence provided by the plaintiff when, in the following paragraph he concluded,

the defendant in my opinion can escape liability only if the proper conclusion is that the plaintiff did not prove that the defendant's failure to warn resulted in her consenting to a procedure that involved a higher risk of injury than would have been the case if the procedure had been carried out by another.<sup>212</sup>

Gummow J also referred to the significance of a finding of duty and breach noting that '... in the absence of evidence that the breach had no effect or that the injury would have occurred even if Dr Chappel had warned her of the risk of injury ... the breach of duty will be taken to have caused the injury.'<sup>213</sup> His suggestion then was that the 'task of Dr Chappel was to demonstrate some good reason for denying to Mrs Hart recovery.'<sup>214</sup> However, he too reached his conclusions through consideration of Mrs Hart's evidence and, as outlined above, the materiality of the risk.

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<sup>211</sup> Ibid, [34] (McHugh J).

<sup>212</sup> Ibid, [35].

<sup>213</sup> Ibid, [68] (Gummow J).

<sup>214</sup> Ibid, [69].

The starting point of Kirby J's consideration of the 'presumption' of causation was to acknowledge the natural sympathy for an injured plaintiff:

Where a breach of duty and loss are proved, it is natural enough for a Court to feel reluctant to send the person harmed (in this case a patient) away empty handed.<sup>215</sup>

He went on to explain and support the possibility of a shifting evidential onus and in similar terms to McHugh J, asserted that, 'once a plaintiff demonstrates that a breach of duty has occurred which is closely followed by damage, a *prima facie* causal connection will have been established.'<sup>216</sup> Kirby J was the only one who carried the discussion to its conclusion and asserted that 'an evidentiary onus lay upon Dr Chappel to displace the inference of causation which thereupon arose. He failed to do so.'<sup>217</sup> This conclusion was not, however, entirely removed from a consideration of Mrs Hart's evidence with respect to causation, as he noted 'Dr Chappel did not displace the inferences to which her evidence gave rise.'<sup>218</sup>

It is clear therefore that there is some sympathy in the High Court for a presumption of causation once duty and breach have been established. This is, however, neither a simple nor decisive presumption. The evidence of the plaintiff continues to inform the determination of liability and the judicial preference appears to be a consideration of both plaintiff and defendant evidence and a determination of which outweighs the other. This has not been the approach of some of the lower Courts however with causation at times attaining the position of a rebuttable presumption, turning on the evidence of the defendant. This is a position which has been described as

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<sup>215</sup> Ibid, [93] (Kirby J).

<sup>216</sup> Ibid, [93], (8).

<sup>217</sup> Ibid, [98].

<sup>218</sup> Ibid, [99].



providing the plaintiff with a path ‘remarkably free of obstacles’<sup>219</sup> and ‘raising the bar for the defendant.’<sup>220</sup> In practical terms, the question of liability for failing to inform simply becomes murkier.

### *Moving beyond Chappel: Elbourne v Gibbs*<sup>221</sup>

[7.130] To suggest that *Chappel* represents an unequivocal acceptance of a shift in evidential onus (and therefore a presumption of causation) is to overlook the significance of both plaintiff and defendant evidence in the decision. It has been suggested that in *Chappel* the shift in onus ‘was applied by the majority merely to confirm the positive result of the ‘but for test’ that had already been obtained’<sup>222</sup> and that perhaps it was neither significant nor decisive. This has not been the position adopted by lower Courts, however, and there has been a general trend towards acceptance of the evidentiary shift as decisive,<sup>223</sup> along with the emergence of a clear presumption of causation once duty and breach are established.

One of the most valuable decisions in this context was handed down by the New South Wales Court of Appeal, *Elbourne v Gibbs*.<sup>224</sup> This decision informs our debate here as it explores the evolution of the *prima facie* case to a concrete presumption.<sup>225</sup> The facts of the case are fairly straightforward. Mr Gibbs was treated by Dr Elbourne for a double hernia. The outcome was disappointing with internal haemorrhaging, a swollen scrotum, chronic pain and a heart attack. Mr Gibbs had a long history of ill health and gave evidence at the trial that he would not have proceeded with the surgery if he

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<sup>219</sup> J. Gunson, „Turbulent Water: The High Court, Causation and Medical Negligence,“(2001) 9 *Tort Law Review* 53, 62-63.

<sup>220</sup> D. Hamer, „Chance Would be a Fine Thing: Proof of Causation and Quantum in an Unpredictable World,“(1999) 23 *Melbourne University Law Review* 557, 627.

<sup>221</sup> [2006] NSWCA 127 (24 May 2006).

<sup>222</sup> Hamer, above n220, 620.

<sup>223</sup> For example refer, *Shed v Hooley* [2000] NSWCA 362, 14 December 2000, *Elbourne v Gibbs* [2006] NSWCA 127, 24 May 2006, *Zaltron v Raptis* [2001] SASC 209, *Bergman v Haertsch* [2000] NSWSC 528, 22 June 2000 and *Johnson v Biggs* [2000] NSWCA 338 24 November 2000.

<sup>224</sup> [2006] NSWCA 127, (24 May 2006).

<sup>225</sup> Whilst this decision post-dates the *Civil Liability Act 2002* (NSW) the facts do not and therefore, s5D does not apply.

had been made aware of the attendant risks. There was no finding of causation at trial with the primary judge focusing on breach.

In the Court of Appeal, a strong dissent was given by Ipp JA who expressed concern at the lack of a specific conclusion with respect to causation. It was his firm position that a finding of causation cannot be implied on the basis of a breach of duty<sup>226</sup> and that the onus is on the plaintiff to prove causation.<sup>227</sup> To ensure that his position was clear, he went on to state clearly that ‘what was said in *Chappel v Hart* and subsequent cases as to the shifting of an evidential onus ... does not assist this Court in determining causation.’<sup>228</sup> His conclusion was to order a re-trial to fully and clearly address evidence pertaining to causation as it was not considered in the primary judgment. He was not prepared to bridge the gap with what he viewed as a poorly formed presumption.

Basten JA<sup>229</sup> on the other hand, embraced the reversal of onus and concluded that causation had been demonstrated in the absence of sufficient proof to the contrary. His interpretation of *Chappel* was that the majority,

Appear to have adopted an approach which accepted that a temporal connection between the breach of duty and the harm suffered, being materialisation of the risk involved in the failure to warn, in the absence of a persuasive contrary explanation, could suffice to establish a relevant causal connection.<sup>230</sup>

This appears to take the position of the High Court a little further, clearly extending the *prima facie* case to a presumption which turns entirely on the

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<sup>226</sup> Ibid, [5]-[6].

<sup>227</sup> Ibid, [11].

<sup>228</sup> Ibid, [23]. It must be noted at this point that this is the same Ipp who chaired the Review of Negligence (the „Ipp Review“), and his position here is consistent with the rejection of the shift of evidential onus outlined above.

<sup>229</sup> With whom Beazley JA concurred.

<sup>230</sup> Ibid, [65] (Basten JA).

evidence of the defendant. It is important to remember that at no point in *Chappel* was the relevance of the plaintiff's evidence with respect to what he or she would or would not have done, either denied or overlooked.

Endeavouring to clarify his position, Basten JA reviewed the decisions post *Chappel* and listed some broad propositions. Of relevance here was his conclusion that the 'degree of connection [between the breach and damage] must satisfy policy underlying the legal attribution of responsibility.'<sup>231</sup> At this point in the judgment his position seemed clear, the inference of causation was accepted and adopted. But then, there was an internal contradiction in his judgment when he noted,

Where it is demonstrated that a defendant has breached a duty owed to a plaintiff, and harm has followed, it would be understandable that the law might impose an onus on the defendant to show that his or her breach of duty had not caused the harm.

*However, that course has not been taken and it is clear beyond doubt that the burden of establishing causation lies on the plaintiff.*<sup>232</sup>

Clear beyond doubt? How then can his next comment be,

On the other hand, in some circumstances the law has accepted that an inference of causation will arise from the existence of a temporal connection, together with other slender support.<sup>233</sup>

The only clarity at this point is that there is no clarity in the test. Basten JA went on to conclude that the 'evidence established a number of objective factors which support the view that, if informed of the risks the plaintiff

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<sup>231</sup> Ibid, [74].

<sup>232</sup> Ibid, [75]. Emphasis added. This is a position entirely consistent with the legislative provisions which uniformly place the onus on the plaintiff.

<sup>233</sup> Ibid.

would not have had the operation, over and above the weight which may be given to his unchallenged evidence that he would not.'<sup>234</sup> Such a conclusion is consistent with the decision in *Rosenberg* in which objective factors overrode the subjective evidence of the plaintiff, and yet there is little consideration of this subjective evidence. Indeed, there is no mention of the subjective test at all. The apparent presumption enabled His Honour to turn away from the plaintiff and overlook the fact that the primary judge did not even address causation and conclude that causation is established. This conclusion rests upon the fact that the defendant did not 'displace' the *prima facie* case 'which follows from the application of *Chappel v Hart*.'<sup>235</sup> This truly is a curious result as it extends the rationale of *Chappel* and elevates causation to a presumption, a position inconsistent with general principles of negligence law. It further retreats from the clear authority of the subjective nature of the causative test and, I would suggest, allows questions of what 'ought' to be done to override well developed principles of negligence law.

If the Courts were permitted to acknowledge the true loss, the one that they are 'intuitively' protecting, this overriding of causative principles would not be necessary. The question would be, did the failure to provide sufficient information harm the patient's right to make an informed choice? The answer would involve a straightforward application of the two-limbed test from *Rosenberg* (and relevant *Civil Liability Act*). The 'but for' link is clear and, if the law sanctioned recognition of this harm, then the normative enquiry would also be straightforward. This is not, however, where the law stands at present and before concluding this analysis of (and challenge to) the approach to causation in Australian Courts, it is worth considering whether the presumption has achieved the aim of protecting the plaintiff's interests.

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<sup>234</sup> Ibid, [88].

<sup>235</sup> Ibid, [105].

*Does the presumption exist and, if it does, is it pro-plaintiff?*<sup>236</sup>

[7.140] A critique of the apparent evidential shift and presumption of causation necessarily raises the question of whether we now have an openly pro-plaintiff approach to negligent advice. The judicial environment has been described as ‘comparatively permissive,’<sup>237</sup> providing the plaintiff with a course ‘to travel and reach the causal destination’ that is ‘free of obstacles that have, until recently, been perceived as impeding that journey.’<sup>238</sup> Conversely, the defendant’s task is seen as more challenging with the Court having ‘raised the bar.’<sup>239</sup> It is true that at first glance, a test that purports to allow the plaintiff to sidestep the most challenging evidential task (establishing causation) could be described as pro-plaintiff. A closer consideration of the decisions, however, demonstrates that causation is by no means a ‘given’ once the plaintiff has established duty and breach. Plaintiffs continue to walk away unsatisfied.

The open scepticism with which Courts view plaintiff assertions<sup>240</sup> regarding what they would have done if provided with appropriate warnings was clearly outlined in the discussion about *Bustos v Hair Transplant*,<sup>241</sup> *Wallace v Ramsay*,<sup>242</sup> *Bergman v Haertsch*<sup>243</sup> and *Rosenberg v Percival*.<sup>244</sup> As none of these decisions embraced (or even addressed) the apparent evidential shift (which is interesting as *Rosenberg* was clearly after *Chappel v Hart* and had three of the same presiding Judges) it is difficult to claim that there has been an evidential

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<sup>236</sup> In exploring this question I am not overlooking the existence of the legislation. I would like to reiterate here the reference to „inferences of causation“ raised by a breach of duty. This issue was recently raised in the New South Wales Supreme Court in the context of the legislation: *Jovanovski v Billbergia* [2010] NSWSC 211, discussed above.

<sup>237</sup> Gunson, above n.219, 54

<sup>238</sup> Ibid, 62-63.

<sup>239</sup> Hamer, above n.220, 627.

<sup>240</sup> Remembering of course that in four jurisdictions, plaintiff evidence in this regard is now limited.

<sup>241</sup> NSWCA, 15 April 1997.

<sup>242</sup> *Wallace v Ramsay Health Care Ltd* [2010] NSWSC 518.

<sup>243</sup> [2000] NSWSC 528.

<sup>244</sup> (2001) 205 CLR 434. In this decision, there is only a brief mention by Gummow J regarding the *prima facie* case as set out in *Chappel v Hart* (1998) 195 CLR 232 with the apparent shifting evidential burden being effectively ignored by the Court.

shift and presumption of causation. Indeed, in *Bergman v Haertsch*<sup>245</sup> Abadee J emphatically stated that ‘mere proof of breach will not of itself be sufficient to establish an entitlement to damages for every harm that thereafter occurs.’<sup>246</sup> However, an equally sceptical Court adopted the evidential shift in the South Australian decision of *Zaltron v Raptis*<sup>247</sup> and the plaintiff still failed to surmount the causation hurdle.

The events in *Zaltron* began with a sore toe and ended with surgical treatment of blockages and amputation of three of the plaintiff’s toes. In presenting the judgment of the Court, Martin J referred to the ‘considerable support’ of the High Court for the ‘concept of a shifting of evidentiary onus,’<sup>248</sup> and ultimately accepted that this support ‘established the principle of a shifting evidentiary onus.’<sup>249</sup> Before concluding whether, in this instance, the application of the principle was pro-plaintiff, a few key factors need to be highlighted. Firstly, the risk which materialised was ‘well known and significant,’<sup>250</sup> and Dr Raptis was clear that he did not warn the patient, and that he felt it was not necessary. His Honour referred to the fact that ‘Dr Raptis plainly stated in evidence that he would not have warned the plaintiff about possible complications,’<sup>251</sup> and that the ‘plaintiff had not been given any information upon which she could make a meaningful decision ... she was somewhat overawed by Dr Raptis.’<sup>252</sup> Furthermore, Dr Raptis’ manner was described as ‘abrupt and domineering’<sup>253</sup> and Martin J acknowledged that not only did Dr Raptis fail to ‘comply with his duty to advise [but] he made no attempt to comply with that duty.’<sup>254</sup> Finally, it was noted that the plaintiff was not asked whether she would have proceeded if she had been told of the risk and this enabled a conclusion at trial that there was no

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<sup>245</sup> [2000] NSWSC 528.

<sup>246</sup> Ibid, [434].

<sup>247</sup> [2001] SASC 209 (4 July 2001).

<sup>248</sup> Ibid, [79] (Martin J).

<sup>249</sup> Ibid, [90].

<sup>250</sup> Ibid, [39].

<sup>251</sup> Ibid, [45].

<sup>252</sup> Ibid, [46].

<sup>253</sup> Ibid, [48].

<sup>254</sup> Ibid, [60].

evidence that she would not have had the operation if warned.<sup>255</sup> Clearly there was a lack of evidence. The plaintiff was not asked and the issue appeared not to have been addressed. The plaintiff in this instance, failed.

The question then is, how can she have failed if there is a *prima facie* case once duty and breach are established and the Court clearly identified that Dr Raptis was domineering in his approach and open about his decision not to comply with his duty? Quite simply, His Honour looked at the facts and concluded that the plaintiff would have proceeded, in part because of the domineering personality of Dr Raptis. The plaintiff 'chose not to give evidence' as to what she would have done<sup>256</sup> and the defendant was able to demonstrate that the diagnosis and treatment was the 'recommended form of treatment.'<sup>257</sup> To suggest therefore that a shift in evidential onus removes all obstacles from the path of the plaintiff, is an oversimplification.<sup>258</sup> Alternatively one cannot conclude that it is pro-defendant as demonstrated in *Shead v Hooley*<sup>259</sup> and *Elbourne v Gibbs*<sup>260</sup> when the defendant was unable to provide sufficient evidence to dislodge the *prima facie* case. It is simply another possible approach, aimed at protecting the plaintiff's right to make a meaningful choice but missing the mark. At best, the shift recognises and attempts to protect this right, as seen in *Chappel v Hart*<sup>261</sup> and at worst it results in a recognition of the harm<sup>262</sup> followed by a compounding of it by admonishing the overbearing doctor but finding that his domineering character would have overawed the plaintiff to such an extent that she would have proceeded with the treatment, even if she did not want to. Thus acceptance of the very harm that lies at the heart of the 'informed consent'

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<sup>255</sup> Ibid, [72].

<sup>256</sup> Ibid, [103].

<sup>257</sup> Ibid, [103].

<sup>258</sup> Refer also *Bergman v Haertsch* [2000] NSWCA 338 (24 November 2000).

<sup>259</sup> [2000] NSWCA 362 (14 December 2000).

<sup>260</sup> [2006] NSWCA 127 (24 May 2006).

<sup>261</sup> (1998) 195 CLR 232.

<sup>262</sup> In *Zaltron v Raptis* [2001] SASC 209, Martin J highlighted the fact that the plaintiff had insufficient information upon which to make a „meaningful decision“ [46].

doctrine serves to defeat the claim. It is difficult to find coherent law in this conclusion.

### **Re-visiting the core issues**

[7.150] Before moving on to considering the position of the United States, we will pause and summarise the position here in Australia through a consideration of the three questions asked in the introduction which the address the core issues discussed here.

#### *What is the test for causation (is it subjective or objective)?*

[7.160] Australian Courts have recognised the risk of relying wholly upon a subjective test of causation and have noted that hindsight ‘will necessarily colour the patient’s response’<sup>263</sup> but have chosen to describe the test as a subjective one. This position is now given legislative force in four of the State jurisdictions and, as we have seen in preceding discussions, is routinely endorsed by the Courts. The practical application of the ‘subjective’ test however, is slightly more complex. In recognising the problematic nature of a purely hypothetical enquiry relying on potentially self-serving testimony, the Courts have endeavoured to walk a middle line and the result has been the emergence of a hybrid test. The common law test reached maturity in *Rosenberg v Percival*<sup>264</sup> and the ‘hybrid’ nature of the test is reflected in the potentially contradictory statements of McHugh J when he began from the position that ‘under the Australian common law ... the test is a subjective test,’<sup>265</sup> then went on to explain that ‘what a reasonable person would or would not have done in the patients’ circumstances will almost always be the most important factor’<sup>266</sup> in reaching a conclusion. Of course we must also

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<sup>263</sup> *Ellis v Wallsend Hospital* (1989) 17 NSWLR 553, 560 (Kirby P).

<sup>264</sup> (2001) 205 CLR 434.

<sup>265</sup> *Ibid*, [24] (McHugh J).

<sup>266</sup> *Ibid*.



remember that this approach is now legislatively endorsed in four jurisdictions which specifically limit the scope of plaintiff evidence,<sup>267</sup> although the practical import of this change is, arguably, limited,<sup>268</sup> with the tests in both common law and legislative provisions having similar judicial processes.<sup>269</sup> In Australia, therefore, we have a test that is described as a subjective one but is better described as a subjective test measured by objective considerations or, a hybrid test.

### *What factors influenced the development of the test?*

[7.170] In Australia the starting point of the judicial enquiry into the provision of pre-treatment advice is the patient before the Court. This is clearly reflected in the patient-centred materiality test which emerged from *Rogers v Whitaker*.<sup>270</sup> The adoption of the subjective test was described by Kirby J in the following terms: it is

more consistent with the traditional principles of tort law ... more respectful of the entitlements of patients whose privilege of choice this area of the law is intended to reinforce. Furthermore, it avoids undermining the social objectives to which the obligation to provide effective warnings is directed.<sup>271</sup>

The aim of the test is thus to keep the patient at the centre of the enquiry. This interest is, however, balanced against the reality of the hypothetical nature of the questions asked and the potential for self-serving assertions of what the patient would or would not have done. In short, it is tempered by the reality

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<sup>267</sup> *Civil Liability Act 2002* (NSW) s5D(3), *Civil Liability Act 2003* (QLD) s11(3), *Civil Liability Act 2002* (TAS) s13(3) and *Civil Liability Act 2002* (WA) s5C(3).

<sup>268</sup> Refer discussion above and the recent decisions of *Wallace v Ramsay Healthcare Ltd* [2010] NSWSC 518 (see text accompanying n.30. In this decision the legislative provision was acknowledged but plaintiff evidence closely scrutinised), *Neal v Ambulance Service of New South Wales* [2008] NSWCA 346 and *KT v PLG & Anor* [2006] NSWSC 919. Also of relevance the discussions of Gleeson and Evans above n.38 and Cockburn and Maddern above n.39

<sup>269</sup> Cockburn and Maddern above n.39, 332.

<sup>270</sup> (1992) 175 CLR 479, outlined and discussed in detail in Chapter 4.

<sup>271</sup> *Rosenberg v Percival* (2001) 205 CLR 434, [154] (Kirby J).

of the human condition, and thus the subjective test is always measured against objective criteria.

*What (if anything) is the problem with the chosen approach?*

[7.180] A significant problem with the current approach is that it is impossible to say with any clarity what the precise nature of the causative test is in Australia. Broadly speaking, it is a subjective test measured against objective factors and there may, or may not, be a presumption of causation once duty and breach have been established. The High Court has clearly indicated a preference for such a presumption but it has been noted that the nature of this apparent presumption is 'unclear.'<sup>272</sup> This uncertainty was reflected in the consideration of the special leave application in *Zaltron*. Kirby J noted that the case was lost on the facts and saw no value in talking about 'these verbal formulae,'<sup>273</sup> whilst Gaudron J was more specific in her statement that 'this is not a suitable vehicle to resolve the differences of opinion expressed in *Chappel v Hart*.'<sup>274</sup> The Ipp Committee<sup>275</sup> rejected any reversal of evidentiary onus and the High Court essentially ignored it in *Rosenberg*. Causation remains a vexed question, with Australian Courts left constructing (and de-constructing) tests in an endeavour to meet the needs of plaintiffs who have suffered a loss, with little clarity added by the legislative intervention. Perhaps the House of Lords was on to something when it ignored the rigours of the negligence framework and simply allowed recovery for Mrs Chester because she ought to recover. Or perhaps an even simpler approach would be to recognise the true nature of the loss suffered and apply a straightforward test of causation asking whether or not the lack of information caused the plaintiff-patient to be denied the right to make an informed choice.

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<sup>272</sup> Hamer, above n220, 557.

<sup>273</sup> *Zaltron v Raptis* A29/2001 (19 April 2002), 4.

<sup>274</sup> *Ibid*, 9.

<sup>275</sup> „Review of the law of Negligence Final Report“, Sep 2002 („The Ipp Report“) [http://revofneg.treasury.gov.au/content/Report2/PDF/Law\\_Neg\\_Final.pdf](http://revofneg.treasury.gov.au/content/Report2/PDF/Law_Neg_Final.pdf), at 18 February 2011, [7.28]-[7.36].

## Chapter 8: The United States of America

### Introduction

[8.10] As we saw in Part I, the Courts in the United States have been identified as the most plaintiff-centric of the three jurisdictions under investigation. In our earlier discussions I challenged this interpretation of the Courts of the United States as the defenders of the individual decision-maker, a challenge I will continue in this Chapter. As we turn to the causation stage of the enquiry, we will see the relegation of patient-autonomy to a position of less importance, indeed in some jurisdictions in the United States, to irrelevance. At the duty and breach stages of the enquiry, the Courts in the United States (as represented by *Canterbury v Spence*<sup>1</sup>) focussed on the individual needs of the plaintiff and emphasised the driving principle of the individual right to information; the causative enquiry represents a shift away from the perspective of the individual, autonomous patient and the emergence of an (apparently) objective test. This shift has meant that causation has been acknowledged as representing the most 'difficult doctrinal hurdle'<sup>2</sup> for the plaintiff.

The test in the United States varies across jurisdictions. Similar to both Australia and the United Kingdom, it is neither a purely objective nor subjective test. Whilst the majority of Courts<sup>3</sup> purport to embrace a purely objective test, a close analysis of the relevant judicial reasoning reveals that on a practical level it is an objective test tempered by subjective considerations.<sup>4</sup> Once again we see the emergence of a hybrid test. The 'objective' approach of the United States turns out to be similar to the

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<sup>1</sup> *Canterbury v Spence* 464 F. 2d 772 (US Court of Appeals 1972).

<sup>2</sup> E. Rauzi, „Informed Consent in Washington: Expanded scope of material facts that the physician must disclose to his patient,“ (1979-1980) 55 *Washington Law Review* 655, 663.

<sup>3</sup> It must be noted at this point that the objective test is enshrined in statute in many of the jurisdictions, see for example N.Y. Pub. H.L. Section 2805-d(3), Fla. Stat. § 766.103 (2007), and WA ST 7.70.050.

<sup>4</sup> As opposed to the Australian test, which is a subjective test tempered by objective considerations.

‘subjective’ one of the United Kingdom and Australia. Importantly, the Courts in the United States continue in the same vein as their counterparts in the United Kingdom and Australia and ask whether or not the plaintiff would have proceeded with the treatment. Individual rights to a meaningful pre-treatment dialogue cease to be important. The enquiry is no longer about information; it is entirely about consent. Where does this leave the plaintiff-patients? Once again, they are on the outer struggling to demonstrate a link between two different forms of harm.

The consideration of the test for causation in the United States will take a slightly different approach from that of the other two jurisdictions. The accepted test clearly utilises objective language. Analysis will focus on some underlying issues which demonstrate that despite this apparent consistency and clarity, the interpretation of what constitutes an objective test varies. This discussion will reveal the basic flaws in the more objective approach, not the least of which is that a truly objective test is potentially illogical.

### **The failure of the subjective test**

[8.20] When it occurs, the rejection of the subjective approach is emphatic. It is, however, based upon a simplistic view of a test based purely upon plaintiff assertions of what they would have done. There are repeated references to the test exposing physicians to risk and enabling the plaintiff’s evidence to dominate.<sup>5</sup> The most common judicial interpretation of the subjective test is that the decision would ‘ultimately turn on the credibility of the hindsight of a person seeking recovery after he had experienced a most undesirable result.’<sup>6</sup> It is this narrow view of the test which has ultimately

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<sup>5</sup> *Canterbury v Spence* 464 F. 2d 772 (1972) , 791 (Robinson J), *Mcpherson v Ellis* 287 S.E. 2d 892 (1982) 896 (Mitchell J), *Cobbs v Grant* 8 Cal.3d 229 (1972), 245 (Benke, Acting PJ), *Fletcher v Medical University of South Carolina* 390 S.C. 458 (2010) 469 (Konduros J).

<sup>6</sup> *Sard v Hardy* 379 A.2d 1014 (1977), 1025 (Levine J).

resulted in its rejection. The test has thus been rejected on the basis of a very narrow, and I suggest flawed, interpretation.

Oklahoma provides a demonstration of the more extreme interpretation of the subjective test. In 1979, the Supreme Court of Oklahoma (*Scott v Bradford*<sup>7</sup>) tackled the objective/subjective divide and determined that only the subjective test was consistent with the foundational principle of the autonomous patient. The plaintiff in this instance had sought treatment for fibroid tumours on the uterus and signed routine consent forms. Unfortunately all did not proceed as planned: following the procedure, the patient had a vesico-vaginal fistula which permitted urine to leak from her bladder. The incontinence was only fixed after a further three surgical interventions. The basis of the claim was that the treating physician had failed to advise her of the risks involved in the procedure or of any available alternatives to surgery.<sup>8</sup>

In delivering his judgment, Doolin J began from first principles and emphasised that 'Anglo-American law starts with the premise of thoroughgoing self-determination.'<sup>9</sup> Consistent with this principle was his view that 'if a physician breaches [his duty to inform], the patient's consent is defective and the physician is responsible for the consequences.'<sup>10</sup> This statement provides an early hint of his conclusions which link the physician's 'wrongdoing' with liability. As will be seen in later discussions, the objective approach focuses on what would have been the decision of the 'reasonable person' in these circumstances, and relies upon the establishment of a direct and clear link between the decision-making processes of the 'reasonable' plaintiff-patient and liability. This was not, however, the approach adopted by the Supreme Court of Oklahoma in this decision; here the Court opted to

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<sup>7</sup> *Scott v Bradford* 606 P.2d 554 (1980).

<sup>8</sup> Facts are drawn from the judgment of Doolin J, 556.

<sup>9</sup> *Scott v Bradford* 606 P.2d 554 (1980), 556 (Doolin J).

<sup>10</sup> *Ibid*, 557.

overlook the decision-making processes, choosing instead to leap directly from 'faulty' advice to an imposition of liability.<sup>11</sup>

The Court acknowledged that the question of appropriate standard was a 'difficult' one<sup>12</sup> and specifically referred to the decision in *Canterbury v Spence*<sup>13</sup> and noted that whilst this seminal decision emphasised the principle of self-determination, it 'only permits liability if non-disclosure would have affected the decision of a fictitious 'reasonable patient' even though the actual patient testifies that they personally would not have proceeded with the treatment if fully informed.'<sup>14</sup> Doolin J went on to reject the 'reasonable man' approach adopted in *Canterbury* on the basis that it 'represents a backtracking on its own theory of self-determination'<sup>15</sup> and jeopardises (the) basic right to know.'<sup>16</sup> His Honour did recognise that the subjective test could be viewed as running the risk of 'plac[ing] a physician at the mercy of a patient's hindsight.'<sup>17</sup> Rather than taking the approach adopted in the Courts of both the United Kingdom and Australia, that of tempering the subjective assertions with objective considerations, he opted simply to point out that if the doctor 'did not breach his duty then a causation problem will not arise.'<sup>18</sup> Thus, if a doctor chooses to withhold information then he or she cannot complain about the impact of subjective experiences and assertions.

This decision serves to demonstrate the impact of value-based judgments on the application of legal principle. Here we have a judge who acknowledged the essential requirement of establishing a causative link but whose decision

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<sup>11</sup> This is perhaps an extreme example of the „presumption“ of causation raised by some Australian Courts and discussed in Chapter 7.

<sup>12</sup> *Ibid.*, 558.

<sup>13</sup> *Canterbury v Spence* 464 F. 2d 772 (1972).

<sup>14</sup> *Scott v Bradford* 606 P.2d 554 (1980),558 (Doolin J).

<sup>15</sup> *Ibid.*, 559. His Honour referred to the criticism to this effect present in some commentary on *Canterbury* and referred specifically to D.Seidelson, „Medical Malpractice: Informed Consent Cases in “Full-Disclosure” Jurisdictions“ (1976) 14 *Duq.L.Rev* 309 and J.Katz, „Informed Consent – A Fairy Tale?“ (1977) 39 *University of Pittsburgh Law Review* 137, a theme that Katz pursued nearly 20 years later in J. Katz „Informed Consent – Must it Remain a Fairytale?“ (1994) 10 *Journal of Contemporary Health Law and Policy* 69.

<sup>16</sup> *Scott v Bradford* 606 P.2d 554 (1980), 559 (Doolin J).

<sup>17</sup> *Ibid.*

<sup>18</sup> *Ibid.*

turned on the existence of mere breach of duty being sufficient to establish liability. In adopting this approach, the Court focussed entirely on the protection granted to the patient. In those jurisdictions applying the objective test, the Courts emphasise the 'risk' to the physician of hindsight evidence and the bitter patient and thus seek to protect the physician. Here, however, the Court was more interested in the basic premise of individual autonomy and, apparently, effective decision-making processes. In an approach similar to that adopted by the High Court of Australia, the Supreme Court of Oklahoma noted that the key to a successful application of a subjective test is to carefully appraise the credibility of the patient's evidence.

If the reasoning of the Court had stopped at that point and suggested how this credibility could be tested (in much the same manner as High Court of Australia has done<sup>19</sup>) then the subjective test may well have won some sympathy in the United States. The Court, however, then took the reasoning one step further. The Court clearly acknowledged the susceptibility of the physician to hindsight bias but merely gave a judicial shrug and suggested that this may well be so but responsibility for this susceptibility is to be laid at the feet of the treating physician. After all, 'a careful practitioner can always protect himself by ensuring that he has adequately informed each patient he treats ... If he does not breach this duty, a causation problem will not arise.'<sup>20</sup> Thus the subjective test of causation becomes no test of causation: if the physician fails to advise, then he or she is liable. In struggling to link the right to information with a subsequent physical harm the Court here simply ignored an essential step of the negligence enquiry and failed to adopt an approach consistent with accepted legal principle. With such a narrow and flawed approach to the subjective test for causation, it is not surprising that this decision has failed to attract support in other jurisdictions in the United

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<sup>19</sup> See for example *Chappel v Hart* (1998) 195 CLR 232, 273 (Kirby J) where His Honour asserted that „tribunals of fact can be trusted to reject absurd, self-interested assertions.“ And, as discussed in Chapter 7, the test for causation in Australia has emerged as a hybrid one in which subjective statements are measured against objective criteria, *Rosenberg v Percival* (2001) 205 CLR 434.

<sup>20</sup> *Scott v Bradford* 606 P.2d 554 (1980), 559 (Doolin J).

States. The majority position among United States Courts is that the subjective test places an unreasonable burden on the medical profession.

### **An objective test**

[8.30] Whilst Oklahoma and the subjective test do not represent the majority approach, it is worth noting that some judges have been reluctant to reject the subjective test but have been bound by precedent or legislation to do so. Some Courts have openly acknowledged the potential conflict between the autonomy of the patient and the objective test, whilst others have recognised the problematic nature of the objective test but equally, have pointed to the problems of the subjective test and chosen to adopt the objective approach as representing the least flawed of the two tests. An example of the latter situation is found in the decision of the Supreme Court of Wisconsin, *Scaria v St Paul*.<sup>21</sup> Beilfuss J (in delivering the judgment of the majority), acknowledged that it is 'conceivable that a jury could find that a reasonable man, when appraised of the risks involved, would have consented to a procedure when in fact the plaintiff would not have consented.'<sup>22</sup> Yet he went on to suggest that the objective test is 'more workable and more fair'<sup>23</sup> on the basis of inherent flaws of the subjective test which is 'not without its margin for error.'<sup>24</sup>

This pragmatic approach is not a universal one. Some Courts have made it clear that they would prefer to apply a subjective test so as to protect the needs of the patient-plaintiff but are constrained by legislation to approach causation objectively. This conflict has given rise to judicial discomfort in some jurisdictions. An example of a dissatisfied Court can be found in the

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<sup>21</sup> *Scaria v St Paul Fire & Marine Insurance Co of Wisconsin* 227 N.W.2d 647 (1999).

<sup>22</sup> *Ibid*, 655 (Beilfuss J).

<sup>23</sup> *Ibid*.

<sup>24</sup> *Ibid*. *Scaria* has more recently been affirmed in *Bubb v Brusky* 768 N.W. 2d 903 (2009) and *Jandre v Physicians Insurance Company of Wisconsin* 792 N.W. 2d 558 (2010).



North Carolina Court of Appeals decision of *Dixon v Peters*.<sup>25</sup> This decision, similar to that of *Bustos*,<sup>26</sup> involved the cosmetic ‘juri flap’ procedure. In delivering the judgment of the Court, Becton J noted that the choice of test for causation is a question giving rise to ‘considerable debate.’<sup>27</sup> Still he was able to evaluate the Court’s view of the objective standard as ‘particularly harsh.’<sup>28</sup> His general dissatisfaction, however, appeared to be aimed more broadly at the problematic nature of the causation enquiry. This is a recurrent theme across all three of our jurisdictions and, as argued in the previous two Chapters, reflects the conceptual problem of linking two disparate interests (the dignitary with the physical). It is relevant to note that whilst Becton J showed a clear preference for the subjective approach and described the plaintiff’s argument as ‘compelling,’<sup>29</sup> he stopped short of enthusiastically embracing it as an effective approach. Rather he referred to it as ‘the lesser of evils.’<sup>30</sup> The Court was, however, constrained by the statutory test of whether the ‘reasonable person under all the surrounding circumstances would have undergone the treatment or procedure had he been advised by the health care provider in accordance with the provisions,’<sup>31</sup> and thus had to reluctantly depart from the preferred, subjective, standard.

It was therefore the view of the North Carolina Court of Appeals that neither the objective nor the subjective tests were adequate. Once again this reflects the problematic nature of the causation enquiry in this context. We see the Courts struggling to reconcile the two distinct stages of the enquiry: the provision of information and the consent to treatment. This problem is perhaps compounded by the Court’s recognition in *Dixon v Peters* that whilst the judicial enquiry into informed consent must begin from the position of the protection of patient interests, the relevant legislative provisions are

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<sup>25</sup> *Dixon v Peters* 306 S.E.2d 477 (1983). This decision focussed primarily on matters of constitutionality of the relevant legislation but made specific comments regarding the nature of both the objective and subjective tests for causation.

<sup>26</sup> *Bustos v Hair Transplant Unrep*, NSWCA, 15 April 1997, discussed in Chapter 7 (see [7.40], [7.140]).

<sup>27</sup> *Dixon v Peters* 306 S.E.2d 477 (1983), 480 (Becton J).

<sup>28</sup> *Ibid*, 481 (Becton J).

<sup>29</sup> *Ibid*.

<sup>30</sup> *Ibid*, 483.

<sup>31</sup> N.C. Gen. Stat. § 90-21.13(a)(3).

driven by ‘policy’ considerations outside of the scope of patient interests. These considerations include, according to Becton J, the recognition that the ‘sole purpose of the legislation was to avoid valid claims.’<sup>32</sup> This is a somewhat curious position when one considers that the doctrine under consideration is widely accepted as being built upon the foundational principle ‘that every individual of adult years and sound mind has a right to decide what may or may not be done with his or her body.’<sup>33</sup>

Despite these misgivings regarding the objective test, it has been emphatically adopted in the majority of jurisdictions in the United States.<sup>34</sup> An early statement of the test is found in *Cobbs v Grant*.<sup>35</sup> The plaintiff was admitted to hospital in August 1964 for the treatment of a duodenal ulcer and whilst she was warned in general terms about the risks of undergoing an anaesthetic, there was no discussion of the risks inherent in this particular procedure. The outcome was not as planned and resulted in a series of operations with 50% of her stomach being removed.<sup>36</sup> It is interesting to note that the discussion began from the position of a needs-based doctrine with Mosk J emphasising that the ‘scope of communications to the patient ... must be measured by the patient’s need.’<sup>37</sup> It then shifted away from the

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<sup>32</sup> *Dixon v Peters* 306 S.E. 2d 477 (1983), 482 referring to a report of the North Carolina Professional Liability Study Commission (1979).

<sup>33</sup> *Schloendorff v The Society of the New York Hospital* 211 N.Y 125 (1914), 129-130.

<sup>34</sup> See for example: *Dixon v Peters* 306 S.E. 2d 477 (N.C. App. 1983), 478, *Davis v Nassau Ophthalmic Services, P.C. et al* 232 A.D. 2d 358 (NY A.D. 1996), 358, *Canterbury v Spence* 464 F. 2d 772 (1972)(decided May 1972) (US Court of Appeals, DC Columbia), 791, *Tribal v Queens Surgi-Center* 8 A.D.3d 555 (2004),557, *Foote v Rajadhyax* 268 A.D.2d (2000) 745, 746, *Barcai v Betwee* 50 P.3d 946 (Hawaii SC 2002), 959, *Snipes v U.S.* 711 F.Supp 827 (District Court, WD North Carolina, Asheville Division, 1989), 829, *Kohoutek v Hafner* 383 N.W.2d 295 (SC of Minnesota, 1986), 299, *Fischer v Wisconsin Patients Compensation Fund* 256 Wis.2d 848 (Court of Appeals of Wisconsin, 2002), 857, *Schreiber v Physicians Ins. Co of Wisconsin* 588 N.W. 2d 26 (SC of Wisconsin, 1999), 33, *Scaria v St Paul Fire & Marine Ins. Co* 227 N.W.2d 647 (SC of Wisconsin, 1975), 655, *Shinn v St James Mercy Hospital* 675 F.Supp. 94 United States District Court, W.D. New York, 1987) 99, *Backlund v University of Washington* 975 P.2d 950 (SC of Washington 1999),955, *Woolley v Henderson* 418 A.2d 1123 (1132)(Mre 1980), 1132, *Zelevnik v Jewish Chronic Disease Hospital* 47 A.D.2d 199 SC, Appellate Division, 2<sup>nd</sup> Department, NY, 1975),207, *Hondroulis v Schumacher MD* 553 So.2d 398 (SC Louisiana 1988),404, *Sard v Hardy* 379 A.2d 1014 (Court of Appeals of Maryland, 1977), 1025, *Cobbs v Grant* 8 Cal.3d 229 (SC California, 1972), 245, *Wilson v Merritt* 142 Cal.App.4<sup>th</sup> 1125 (2006), 1138 and *Fletcher v Medical University of South Carolina* 390 S.C. 458 (2010) 461.

<sup>35</sup> *Cobbs v Grant* 8 Cal.3d. 229 (SC California, 1972). This decision continues to be cited as a decision of authority. See for example *Bubb v Brusky* 768 N.W. 2d 903 (2009) , *Hernandez ex rel. Telles-Hernandez v US* 665 F.Supp.2d 1064 (2009),*Murillo v Millner* , Not reported in C. Rptr. 3d (2010) and *Applewhite v Department of Veterans Affairs* 364 Fed.App 97 (2010).

<sup>36</sup> *Cobbs v Grant* 8 Cal.3d. 229 (1972) facts taken from the judgment of Mosk J, 234.

<sup>37</sup> *Ibid*, 245.

individual patient towards the objective 'reasonable' patient. This shift was driven by an interest in doing 'justice.' The Court readily acknowledged that the patient may subjectively believe, 'with 20/20 vision of hindsight' that he would have declined the treatment, yet could not rely upon this evidence because of their 'doubt that justice will be served by placing the physician in jeopardy of the patient's bitterness and disillusionment.'<sup>38</sup> It is this protection of the treating physician that drives much of the reasoning, in this and other decisions, including *Canterbury v Spence*, which is almost universally described as representing the patient-centric doctrine of informed consent.<sup>39</sup>

The next question then is what role does the evidence of the patient actually play? Is it of any relevance to the objective process or is the specific individual relegated entirely to the sidelines? Whilst the individual rights and interests of the patient are readily acknowledged at the duty stage of the enquiry, some jurisdictions have excluded them from consideration when turning their minds to the causation question. In New York and North Carolina for example, it has been specifically noted that it is not a problem if the patient does not testify.<sup>40</sup> This position was taken even further in *Snipes v U.S.* when the Court stated that what the 'plaintiff would have done is neither here nor there.'<sup>41</sup> This exclusionary view of the plaintiff is, however, limited with the majority of jurisdictions adopting the *Canterbury* position that plaintiff evidence is 'relevant but not determinative.'<sup>42</sup> Thus the plaintiff patient continues to be of relevance but in an apparently more limited sense than in the subjective test. The Supreme Court of Wisconsin endeavoured to clarify this when they concluded that 'the objective, reasonable man approach is more workable and more fair in that it allows the jury to consider the

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<sup>38</sup> Ibid.

<sup>39</sup> *Canterbury v Spence* 464 F. 2d 772 (1972), rejected the subjective test on the basis that it „places the physician in jeopardy of the patient’s hindsight and bitterness.“ 790-791.

<sup>40</sup> *Davis v Nassau Ophthalmic Services, P.C. et al* 232 A.D. 2d 358 (1996), 360 and *Dixon v Peters* 306 S.E. 2d 477 (1983),484.

<sup>41</sup> *Snipes v US* 711 F.Supp 827 (1989), 830.

<sup>42</sup> *Canterbury v Spence* 464 F. 2d 772 (1972), 207. See also *Sard v Hardy* 379 A.2d 1014 (1977), 1025, *Zeleznik v Jewish Chronic Disease Hospital* 47 A.D.2d 199 Supreme Court (1975), 207 and *Shinn v St James Mercy Hospital* 675 F.Supp. 94 (1987). This test includes such variations as „relevant but not controlling“ *Sard v Hardy* 379 A.2d 1014 (1977), 1026.

plaintiff's testimony as to how he would have responded without being forced to engage solely in a test of the credibility of the plaintiff's hindsight after an undesirable result.<sup>43</sup> This process in fact draws the 'objective' test closer to the 'subjective' (or in reality, hybrid) test as discussed in *Rosenberg*<sup>44</sup> with the patient evidence being weighed against the objective factors of what a reasonable person in their position would have done.

### **An objective test informed by subjective elements.**

[8.40] Despite assertions that the preferred test is a purely objective one which contains no subjective elements, it is quite clear that every Court which applies the objective test to determine causation imports the subjective characteristics and interests of the plaintiff before them. It is illustrative to begin with one of the strongest rejections of plaintiff evidence, reflected in the position that what a particular patient would have done was 'neither here nor there'<sup>45</sup> which, on the surface, treats individual patient differences as irrelevant. In this instance the Court was considering a gastric stapling that had not gone well and despite the Court's insistence that the test is objective and rejection of the particular patient's probable course of action as irrelevant, close consideration of the 'objective' process demonstrates the significance of subjective considerations. The Court noted that the plaintiff viewed this procedure as his 'last resort' and referred to the evidence that he was aggressive in his insistence that he have this surgery.<sup>46</sup> It was also deemed to be relevant that he had an 'urgent indication for this operation' and that 'if ever there was a person who could be called the perfect candidate

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<sup>43</sup> *Scaria v St Paul Fire & Marine ins. Co* 227 N.W.2d 647 (1975), 655

<sup>44</sup> *Rosenberg v Percival* (2001) 205 CLR 434, see discussion in Chapter 7 (see [7.50]ff).

<sup>45</sup> *Snipes v U.S.* 711 F.Supp 827 (1989), 830.

<sup>46</sup> *Ibid*, 829. It is interesting to note here that these comments are similar to those of the Court in *Harris v Bellemore* [2010] NSWSC 176 where Bellemore J emphasised the plaintiff's desire for treatment [148] and „extreme devotion“ to the surgical path [149].

for gastric stapling, [the plaintiff] was that person.’<sup>47</sup> Thus the objective test clearly becomes imbued with subjective considerations.

The subjective component of the objective test is in fact reflected in the description of the objective test which talks of the ‘surrounding circumstances’<sup>48</sup> and, goes so far as to extend the reasonable person test to that of the reasonable person ‘standing in his or her shoes.’<sup>49</sup> This placing of the ‘reasonable person’ in the context of the individual plaintiff empowers the Court to consider such subjective elements as the nature of the condition, the age and perhaps even any particular susceptibilities of the plaintiff.

The introduction of idiosyncratic considerations once again aligns the specifically objective test with the considerations set out in Australia in *Rosenberg*.<sup>50</sup> When a patient suffered a stroke following an arteriogram for example, the Court of Appeal of Louisiana felt it relevant to consider the condition of the patient at the time of the decision, the necessity for treatment, the seriousness of the undisclosed consequences occurring and the measures available for the correction of the consequences should they occur.<sup>51</sup> These factors clearly echo those set out in *Rosenberg*<sup>52</sup> and were extended even further in *Backlund v University of Washington*<sup>53</sup> when the Court specifically referred to the characteristics of the situation of the plaintiff patient including their medical condition, age and risk factors. These factors then guided the Court to ‘make findings of fact regarding the risks of the treatment and any material risks regarding treatment alternatives.’ Based on these findings the Court then concluded what a ‘reasonably prudent patient’

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<sup>47</sup> Ibid. Again it is relevant to refer to an Australian decision, consider *Wallace v Ramsay Health Care Ltd* [2010] NSWSC 518 where Harrison J carefully considered the need of the plaintiff for the procedure and pointed out that his „desperate preoperative plight” meant that this procedure was most appropriate for him [94].

<sup>48</sup> See for example: *Dixon v Peters* 306 S.E.2d 477 (1983),479 and *Snipes v U.S.* 711 F.Supp 827 (1989), 829.

<sup>49</sup> *Snipes v U.S.* 711 F.Supp 827 (1989), 829.

<sup>50</sup> *Rosenberg v Percival* (2001) 205 CLR 434, see Chapter 7, The subjective approach in the High Court: *Rosenberg v Percival* (at [7.50]).

<sup>51</sup> *Yahn v Folse* 639 So. 2d 261(1993), 268.

<sup>52</sup> *Rosenberg v Percival* (2001) 205 CLR 434, see Chapter 7, The subjective approach in the High Court: *Rosenberg v Percival* (at [7.50]).

<sup>53</sup> 975 P.2d 950 (1999).

would have chosen.<sup>54</sup> Thus the gulf between the 'subjective' test in Australia and the 'objective' test in the United States is narrower than the choice of language tends to indicate.

The role of subjective elements within the objective framework is further illustrated in a decision from Alabama: *Fain v Smith & Ors*.<sup>55</sup> An injured patient and his wife brought an action for a failure to inform of the risk of perforation during the performance of a pulmonary arteriogram. The majority judgment emphatically applied the objective test and identified causation as the 'primary point of difference between the parties on appeal.'<sup>56</sup> It was noted that the plaintiffs sought an application of the subjective standard which was described as being 'judged solely by the testimony of the plaintiff that he would not have consented [and] exclusively on the basis of the credibility of the testimony of the patient.'<sup>57</sup> It is no wonder therefore that this narrow form of the subjective test was readily rejected by the Court as it relies entirely on one component of relevant evidence, and as explained above, does not reflect the practical reality of the subjective test as applied in either the United Kingdom or Australia.

In turning to the objective test, the majority in *Fain v Smith & Ors* rejected the plaintiff's contention that 'the objective standard does away with consideration by the jury of the patient's testimony concerning his thoughts.'<sup>58</sup> In the view of the Court the plaintiff's evidence is 'pertinent' and 'occupies the same place in the jury's deliberative processes that the testimony of a defendant charged with assault with intent to kill occupies when that defendant testifies that he did not intend to kill the other party.'<sup>59</sup> In other words, in much the same manner as the High Court in *Rosenberg v*

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<sup>54</sup> *Ibid*, 959.

<sup>55</sup> 479 So.2d 1150 (1985).

<sup>56</sup> *Ibid*, 1152.

<sup>57</sup> *Ibid*.

<sup>58</sup> *Ibid*, 1154.

<sup>59</sup> *Ibid*.

*Percival*,<sup>60</sup> the jury will ‘take the testimony into consideration along with other facts in determining whether the testimony is to be believed.’<sup>61</sup> Thus the patient’s assertion that he would not have agreed to the surgery is tested against a more objective view of the facts and this would include the severity of the illness, likelihood of the risk manifesting and other relevant background features.

### **Re-visiting the core issues**

[8.50] With the United States being commonly referred to as the most patient-friendly of the three jurisdictions under consideration, it at first appears puzzling that there is clear judicial and legislative support for a shift away from individual patient interests when addressing the question of causation. However, this shift does not represent a significant departure from the approach adopted in the other two jurisdictions: again it involves a combination of both subjective and objective factors. Before drawing the last three Chapters together and considering the practical import of the evolution of different tests in each jurisdiction, we will pause and re-visit the questions asked in the introduction.

#### ***What is the test for causation (is it subjective or objective)?***

[8.60] The approach to causation in the United States appears to be the most straightforward of the three jurisdictions. Whilst there is some support for a subjective approach, the majority position is clearly, and emphatically, objective. The language employed is that of the ‘reasonable patient’, or, as explained by the *Canterbury* Court:

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<sup>60</sup> (2001) 205 CLR 434.

<sup>61</sup> *Fain v Smith & Ors* 479 So.2d 1150 (1985), 1154.

... 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.<sup>62</sup>

The acceptance of the objective position however is not consistent across all jurisdictions in the United States. The nature of the concerns about the adoption of an objective test were explained by the Court in *Scott v Bradford*.<sup>63</sup> The Court here, in the process of rejecting the objective test, lamented the disappearance of the autonomous patient in other jurisdictions. Of note was the position that the *Canterbury* 'view severely limits the protection granted an injured patient.' The Court even went so far as to find that 'a patient's right of self-determination is irrevocably lost.'<sup>64</sup> Of significance is the appeal to the fundamental right 'to know and decide' as the 'reason for the full disclosure rule' which then led the Court to 'decline to jeopardise this right by the imposition of the "reasonable man" standard.'<sup>65</sup>

Despite concerns such as these, the position in the United States remains predominantly objective. As we saw in the preceding discussion however, the objective approach is tempered by subjective considerations. The language is clearly that of the 'reasonable' person as opposed to the individual patient, but considerations of the individual characteristics can, and do (as we have seen) become relevant. Thus it is most accurate to describe the majority position of the United States as representing a linguistically objective test which imports subjective elements. In practical terms it is, similarly to Australia and the United Kingdom, a hybrid test.

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<sup>62</sup> *Canterbury v Spence* 464 F. 2d 772 (1972), 792.

<sup>63</sup> 606 P.2d 554 (1979).

<sup>64</sup> *Ibid*, 559.

<sup>65</sup> *Ibid*.



*What factors influenced the development of the test?*

[8.60] The majority position in the United States reflects a rejection of the subjective test because it is seen to be dealing with hypothetical answers to hypothetical questions and thus incapable of reflecting reality. This position was clearly stated in *Canterbury v Spence*<sup>66</sup> when the Court noted that '[w]hen causality is explored at a post injury trial with a professedly uninformed patient ... the question becomes purely hypothetical [and] ... places the physician in jeopardy of the patient's hindsight and bitterness.'<sup>67</sup> Taking this reasoning one step further, *Zelevnik v Jewish Chronic Disease Hospital*<sup>68</sup> contains the following assertion: 'Whether in fact he would have refused the proposed therapy in the face of known risks is an altogether hypothetical question ... No-one, least of all the patient, can answer that question with reasonable certainty and the physician is placed at the mercy of the patient's hindsight.'<sup>69</sup> Similarly, and more recently, the Court of Appeals of South Carolina found that 'proof of causation under a subjective [test] would ultimately turn on the credibility of hindsight of a person seeking to recover after he had experienced a most undesirable result. Such a test puts the physician in "jeopardy of the patient's hindsight and bitterness."<sup>70</sup>

It would appear that not only the judiciary, but also the legislatures, have been influenced by concern for the doctor. This was explored in *Dixon v Peters*<sup>71</sup> where the presiding Judge asserted that the passing of the relevant legislation was influenced by a report commissioned by the North Carolina Professional Insurance Study Commission. This report, according to Becton J, 'clearly reveal[ed] that the sole purpose of the legislation was to avoid valid claims.'<sup>72</sup> Thus, in an extraordinary shift from the patient-centred duty and

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<sup>66</sup> 464 Fed R 2d 772 (1972).

<sup>67</sup> Ibid, 790 (Robinson J).

<sup>68</sup> 47 A.D.2d 199 (1975).

<sup>69</sup> Ibid, 207(Martuscello Acting P.J).

<sup>70</sup> *Fletcher v Medical University of South Carolina* 390 S.C. 458 (2010) 469 (Konduros J).

<sup>71</sup> 306 S.E. 2d.477 (1983).

<sup>72</sup> Ibid, 483 (Becton J).

breach stages of the enquiry we see that the driving principle behind the development of the objective test is clearly concern for the doctor and a desire to protect them from the patient. This raises the question: if we are protecting the patient from the paternalistic doctor at the duty and breach stages of the enquiry, and then protecting the doctor from the disillusioned patient at the causative stage of the enquiry, how can the interests of either be effectively addressed?

*What (if anything) is the problem with the chosen approach?*

[8.80] One of the main concerns with a purely objective approach is that it diverts attention away from the central character of the 'informed consent' enquiry: the patient. This position was explored in an interesting, and strong dissent in *Fain v v Smith and Ors*<sup>73</sup> when Jones J rejected the position of the majority, preferring instead to adopt the subjective test. In his view, the 'majority opinion, at the very least, substantially compromises the fundamental right of self-determination ... and diverts the focus of the jury's determination of causation away from the patient.'<sup>74</sup> This view of the objective test is reinforced in scholarly discussions of the doctrine of informed consent. It has been argued that the suggestions that 'the test for causation undermines the liability standard is hardly debatable'<sup>75</sup> and that it is 'inconsistent with the rationale of patient sovereignty.'<sup>76</sup> More significantly, however, not only does a purely objective test represent an undermining of patient rights, it is potentially illogical.

The objective test is based upon the so-called 'reasonable person' who does not actually exist and may not reflect the reality of the individual before the Court. The answer to the question, 'would a reasonable person have

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<sup>73</sup> 479 So.2d 1150 (1985).

<sup>74</sup> Ibid, p1156.

<sup>75</sup> A.D. Twerski, N.B. Cohen, *Informed Decision Making and the Law of Torts: The Myth of Justiciable Causation* (1988) *University of Illinois Law Review* 607, 614.

<sup>76</sup> Rauzi, E, *Informed Consent in Washington: Expanded Scope of Material Facts that the Physician Must Disclose to His Patient* (1979-1980) 55 *Washington Law Review* 655, 662.

undertaken this treatment' is problematic as it undermines the particular medical treatment under consideration: it means that the treatment offered is an inappropriate one as no right thinking/reasonable person would have undertaken it. If a true and careful evaluation of the question is to occur, then the reasonable person must adopt some of the characteristics of the plaintiff.

The limitation of the reasonable person test in this context was recognised in *Snipes v U.S.*<sup>77</sup> when the Court noted that,

Since Snipes was an ideal candidate for this operation, to say that he could have intelligently or reasonably refused it if better informed is to say that every other person who was a candidate for it at about the same time should have refused it as well.

In turn, this would imply that the medical profession was perpetrating a massive fraud, or at least massive bad judgment in recommending this operation to thousands of patients. It suggests that the patients could have prescribed better treatment for themselves than their doctors were prescribing for them.<sup>78</sup>

In short, the 'reasonable person' must be given some of the characteristics of the actual plaintiff if the test is not to undermine the medical profession by suggesting that the patient, as opposed to the doctor, is best suited to assessing their medical treatment.

Thus a purely objective test is potentially as flawed as a subjective test and represents a significant shift away from the needs of the patient. And whilst the position in the United States appears to represent the clearest and least problematic statement of a test for causation, it fails to address the specific problem of linking a physical loss with the dignitary harm that occurred

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<sup>77</sup> 711 F.Supp 827 (1989).

<sup>78</sup> Ibid, 830. It is interesting to note that the Court went on to apply the objective test.

when the patient was given inadequate information. Once again it must be emphasised that the latter harm is crucial to the duty-and-breach enquiry but becomes irrelevant when seeking the causative link. What we are seeing here is the continued struggle for balance between patient and physician rights, a struggle which is evident in both of the other jurisdictions. The problematic nature of the enquiry is noted in some of the commentary. For example Waltz and Scheuneman discuss the 'slippery and complex' nature of the concepts surrounding the doctrine of 'informed consent' and note that 'there can be little wonder that doctors have been concerned that Courts have been less than precise.'<sup>79</sup> The role of causation in protecting the interests of the physician is addressed by Rauzi who suggests that an expansion of the doctrine could upset the 'decisional balance between patient and physician.'<sup>80</sup> Significantly, the Courts and legislature are taking care 'not to relegate the healthcare profession to strict liability.'<sup>81</sup> A balance of rights and interests is important but with judicial energies focussed on striking a balance, the true nature of the loss is overlooked and the patient ceases to be empowered to make an informed choice.

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<sup>79</sup> J. Waltz and T.Scheuneman, „Informed Consent to Therapy“, (1970) 64 *Northwestern University Law Review* 628, 649.

<sup>80</sup> Rauzi, above, n.76 p.656.

<sup>81</sup> *Woolley v Henderson* 418 A.2d 1123 (1132)(Mre 1980), p.1129.

## Chapter 9: Bringing it all Together

### Causation and policy

[9.10] In the preceding three Chapters we have been exploring the nature of the test for causation and considering the apparent doctrinal divide between the objective and subjective approaches. I describe this as an ‘apparent’ doctrinal divide because close analysis of the application of the three tests reveals that the differences are linguistic as opposed to practical. Each jurisdiction purports to apply a test that sets it apart from the other two jurisdictions, yet the outcome is, more often than not, the same: the plaintiff fails in their action. Whilst the language used in each jurisdiction may differ, the practical application is much the same. In the rare situation that a plaintiff succeeds (such as *Chester v Afshar*<sup>1</sup> and *Scott v Bradford*<sup>2</sup>) the Court usually has to step outside of the specific requirements of the traditional negligence framework. As outlined in Chapter 6 (see [6.70]-[6.90]), in *Chester* this meant that whilst the Court acknowledged that there was no legal causation, they deemed that the plaintiff had a meritorious claim, therefore they ruled in her favour. And in *Scott v Bradford* liability was founded on mere breach with a non-existent test for causation.

If we return to the issue with which this thesis is concerned, the importation of the trespassory concept of consent into considerations of an exchange of information and thus the negligence framework, we see that it is here, at the causation stage of the enquiry, that the doctrine of ‘informed consent’ truly falls apart. The adoption of the language of consent has resulted in the creation of an ‘evidentiary gap’.<sup>3</sup> The Courts struggle to link the right to information (which I describe as a dignitary right concerned with one’s

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<sup>1</sup> [2005] 1 AC 134.

<sup>2</sup> 606 P.2d 554 (1980), discussed in Chapter 8.

<sup>3</sup> Once again I am adopting the language introduced by Jane Stapelton, „Lords A’Leaping Evidentiary Gaps“ (2002) 10 *Torts Law Journal* 276.

personal dignity and unrelated to the external or physical well-being) to the trespassory notion of consent. The sought-after link is illogical and thus represents a gap in reasoning that cannot be bridged in a principled manner. One tool that the Courts have used to ‘leap the evidentiary gap’ has been an appeal to policy.<sup>4</sup> We need to understand these, at times incoherent, appeals to policy to truly understand the problematic nature of the search for the missing causative link.

### **The policy diversion**

*“I, for one, protest, as my Lord has done, against arguing too strongly upon public policy; - it is a very unruly horse, and when once you get astride it you never know where it will carry you. It may lead you from the sound law. It is never argued at all but when other points fail.”* (Burroughs J)<sup>5</sup>

[9.20] The role of policy in judicial decision-making is widely debated. Policy is often perceived as the ‘opt out’ clause, the tool brought in to reach a conclusion in difficult situations. Appeals to public policy usually occur (as noted by Burroughs J nearly 200 years ago) when the answer, or indeed even the argument, is unclear. This approach is more likely in complex situations such as consent to treatment when it is difficult to apply established principles to identify a link between the legally recognised harm and the negligence act.

The role of policy in the ‘informed consent’ decisions has been highlighted in the preceding Chapters and warrants closer consideration. This discussion is included here to clarify why the judiciary has turned to policy, as opposed to

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<sup>4</sup> See for example the references to policy in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, 585-586 (McNair J) where the social utility of treatment is emphasised, and *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1984] QB 493 in which there is a sense of the decision being driven by the need to protect the doctor and the provision of medical treatment unencumbered by concerns of litigation (these were outlined in Chapter 3). Of course policy emerged fully fledged in *Chester v Afshar* [2005] 1 AC 134 and here in Australia, Fitzgerald JA referred to the policy of entitling a competent person to make his or her own decision about his or her own life, *Dr Ibrahim v Arkell* [1999] NSWCA 95, [33] and in *Rosenberg v Percival* (2001) 205 CLR 434, 480 Kirby J made specific reference to policy.

<sup>5</sup> *Richardson v Mellish* (1824) 2 Bing 229, Burroughs J, 303.

legal principle, in the informed consent decisions. I will suggest that the reason for resort to policy lies not in the lack of principle but in misplaced focus. The judicial enquiry begins with duty and breach and a careful consideration of the individual right to information but then, at the causation stage of the enquiry, shifts to the manifestation of a physical harm. This shift in focus requires the potentially illogical linking of two unrelated harms: a dignitary and a physical one. It is here that we see the judiciary presented with a challenge that cannot be met without resort to loose 'policy' claims.

### *Policy in the consent decisions*

[9.30] The term 'policy' or 'public policy' defies clear and specific definition. Indeed it has been described as 'one of the most under-analysed terms in the modern legal lexicon.'<sup>6</sup> It is a fluid concept which is, at times, employed by the judiciary to meet a perceived need. This is particularly relevant in the context of the 'informed consent' decisions.

It is in the United Kingdom that appeals to policy are most commonly made. It was noted in Chapter 6 that there has been a consistent pattern of placing emphasis on the social utility of treatment and in 2005, in *Chester v Afshar* (*Chester*)<sup>7</sup> the House of Lords clearly, and emphatically, addressed policy considerations such as social utility and questions of whether a plaintiff 'ought' to recover at the expense of established causative principles.<sup>8</sup> In the foundational decision of *Bolam v Friern Hospital Management Committee* (*Bolam*)<sup>9</sup> policy was described as a relevant consideration<sup>10</sup> and again in *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* (*Sidaway*)<sup>11</sup> the need to focus on broader interests than those

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<sup>6</sup> P. Cane, „Another Failed Sterilisation“ (2004) 120 *Law Quarterly Review* 189, 191.

<sup>7</sup> [2005] 1 AC 134.

<sup>8</sup> The significance of policy in *Chester* was outlined in Chapter 6, see specifically Manipulating causation: *Chester v Afshar* (at [6.70]).

<sup>9</sup> [1957] 1 WLR 582.

<sup>10</sup> *Ibid*, 586 in consideration of the social utility of the provision of medical treatment.

<sup>11</sup> [1984] QB 493.

represented by one patient were emphasised, along with the need to avoid the practice of defensive medicine which would potentially cripple medical advancement.<sup>12</sup> The rationale underlying this conclusion was that to impose an onerous duty to warn would create an overly cautious medical professional, unwilling to advance or try out new treatment. *Bolitho v City Hackney Health Authority (Bolitho)*<sup>13</sup> completed this triumvirate of cases and acted to reinforce the doctor-centric policy base of earlier decisions, thus preparing the ground for the emphatically policy driven decision of *Chester*.

The difficult decision of *Chester* saw the House of Lords openly embracing policy as a driving consideration in decisions such as these. The problem with this approach is, as identified in Chapter 6, that whilst the Lords all referred to and relied upon policy, it was not always the same ‘policy’. In the view of Lord Bingham, the appropriate policy consideration was the underlying purpose of negligence law as a whole,<sup>14</sup> whilst the majority looked to the underlying ethos of the duty to warn of the risks inherent in medical treatment.<sup>15</sup> And, in still a different approach again, Lord Steyn struggled to fit the enquiry into the existing negligence framework and application of the ‘but for test.’ This resulted in an unconvincing conclusion based on the reduced likelihood of a small risk materialising if the operation was delayed.<sup>16</sup>

In Australia, policy considerations have not been as openly accepted as in the United Kingdom, but nevertheless they sit behind much of the judicial reasoning in the consent decisions. Whilst the High Court has readily acknowledged that ‘value judgments’ and ‘considerations of policy’ enter

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<sup>12</sup> *Ibid*, 893 (Lord Diplock).

<sup>13</sup> [1998] AC 232. *Bolitho* was discussed in detail in Chapter 3 under the heading The Courts: Putting a gloss on the professional standard test (at [3.80]).

<sup>14</sup> *Chester v Afshar* [2005] 1 AC 134, [7] (Lord Bingham).

<sup>15</sup> This was outlined in detail in Chapter 6, under the heading Manipulating causation: *Chester v Afshar*: The decision (at [6.90]).

<sup>16</sup> This reasoning was flawed because it is based on a „lightning never strikes twice“ principle, that is a small risk materialised at this time, therefore it will not materialise at another time. See discussion in Chapter 6 regarding Lord Hoffman’s discussion of the *Casino* rationale and Lord Steyn’s subsequent application of this rationale. Also refer *Chester v Afshar* [2005] 1 AC 134 [31], (Lord Hoffman) and [11] (Lord Steyn).



into 'intangible question of responsibility' in the negligence enquiry,<sup>17</sup> it has carefully avoided openly embracing policy based decisions. There is a consistent endeavour to place the negligence discussion within a setting of principle but the Court often returns to the significance of broader 'normative considerations,' such as 'values or policy'<sup>18</sup> acknowledging that the issues under consideration in this context do not always sit comfortably within the existing framework.

An illustrative example is found in the decision of *Chappel v Hart*.<sup>19</sup> As noted in Chapter 7, this decision saw the High Court avoiding the language of policy, opting instead for the 'common sense' test developed in *March v Stramare*,<sup>20</sup> and so aiming for a principled approach to the law. Close examination of *Chappel v Hart* in Chapter 7, however, revealed that the 'common sense' test necessarily involved the introduction of value judgments. When the concept of common sense is scrutinised, it is clear that the term requires individual, and often idiosyncratic, interpretations of what constitutes both common and sense. And in *March v Stramare*, Kirby J openly embraced the importance of 'policy' considerations (which necessarily involve individual value judgments) and highlighted the necessarily normative qualities entrenched in the general legal propositions raised in the causation enquiry.<sup>21</sup> Thus whilst policy as a term is not employed, the underlying process is driven by similar considerations as those found in the decisions from the United Kingdom which specifically refer to policy considerations.<sup>22</sup> These policy considerations range from views of the purpose of negligence law as a whole through to individual interpretations of what is just and right in the circumstances.

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<sup>17</sup> *March v Stramare* (1991) 171 CLR 506, 524 (Toohey J).

<sup>18</sup> See for example Gleeson CJ in *Travel Compensation Fund v Tambree* (2005) 224 CLR 627, 639.

<sup>19</sup> (1998) 195 CLR 232, discussed in some detail in Chapter 7 (at [7.80]ff).

<sup>20</sup> (1991) 171 CLR 506, this would of course now involve consideration and application of the relevant legislative provision.

<sup>21</sup> *March v Stramare* (1991) 171 CLR 506, [93].

<sup>22</sup> The role of policy in the decisions from the United States is, like those in Australia, rarely enunciated but occasionally acknowledged. See discussion in Chapter 8.

Despite the paucity of open acknowledgement of policy in Australian judicial discussion, the reality is that something more than a strict application of principle has driven the ‘informed consent’ decisions. This was acknowledged in *Elbourne v Gibbs*<sup>23</sup> when, following an analysis of post *Chappel* decisions, Basten JA emphasised that the connection between breach and damage (that is, causation) must ‘satisfy the policy underlying the legal attribution of responsibility.’<sup>24</sup> Similarly in *Dr Ibrahim v Arkell*<sup>25</sup> Fitzgerald JA noted that the ‘informed consent’ decisions are driven by the ‘policy requirement entitling a competent person to make his or her own decision about his or her life.’<sup>26</sup> Thus we have the broad notion of a policy which serves to preserve the rigour of the law alongside a narrower, individual needs-based policy aimed at preserving the personal integrity of the plaintiff-patient. This opens the question of what is the dominant ‘policy’ consideration, how is it formed and how can potentially conflicting ‘policies’ be reconciled? It is the inability to answer this question with any certainty that lies at the heart of my concern about the role of policy (both explicit and implicit) in the ‘informed consent’ decisions. In seeking to identify the appropriate role of policy in this context I will first consider the role of policy in judicial decision-making in general and then return to the narrower focus of the ‘informed consent’ decisions. The aim here is to determine whether policy has a legitimate place in these decisions. This will involve addressing the questions as to the nature of the policy driving these decisions and whether that policy can be reconciled with the protection of an individual’s right to choose.

*The policy/principle divide: Is there a distinction and is it important?*

[9.40] A common distinction made by both commentators and the judiciary is between policy and principle. It is equally common to deny that there is a

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<sup>23</sup> [2006] NSWCA 127 (24 May 2006).

<sup>24</sup> *Ibid*, [74].

<sup>25</sup> [1999] NSWCA 95.

<sup>26</sup> *Ibid*, [33].

distinction between the two and to emphatically state that they are indistinguishable and interdependent. It is important therefore to begin any critical assessment of the role of policy in the consent decisions with a consideration firstly, of whether there is a clear divide between policy and principle and secondly, is this divide (or lack thereof) important?

There is a mix of views regarding the apparent principle/policy dichotomy with one consistent thread running throughout: the relationship between the two is problematic. Some scholars, such as Ronald Dworkin clearly differentiate between policy and principle. Dworkin defines policy as a 'kind of standard that sets out a goal to be reached, generally an improvement in some economic, political or social feature of the community' and principle as 'a standard that is to be observed ... because it is a requirement of justice or fairness or some other dimension of morality'<sup>27</sup> Conversely, Stapleton describes it as 'odd' that 'some Australian lawyers still believe that there is a meaningful tension between principle and policy,'<sup>28</sup> and suggests that 'we should ditch both "principle" and "policy" terminology.'<sup>29</sup> Most commentators and members of the judiciary sit somewhere between these two views, variously referring to the 'supposed distinction,' between policy and principle,<sup>30</sup> or viewing them as 'inseparable' and 'complementary strands of the one rope,'<sup>31</sup> and 'not always easy to distinguish.'<sup>32</sup> In contrast, Beever refers to 'policy and its contrary principle.'<sup>33</sup> A further complication is the potential for distinction between 'public' policy and 'legal' policy: whilst the

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<sup>27</sup> Ronald Dworkin, *Taking Rights Seriously* (Duckworth, London, 1979), 22.

<sup>28</sup> J. Stapleton, „The Golden Thread at the Heart of Tort Law: Protection of the Vulnerable,“ (2003) 24 *Australian Bar Review* 135, 135.

<sup>29</sup> *Ibid*, 137.

<sup>30</sup> C. Witting, „Tort Law, Policy and The High Court of Australia“ (2007) 31 *Melbourne University Law Review* 569, 571.

<sup>31</sup> *Ibid*, 9.

<sup>32</sup> H. Luntz, „The Use of Policy in Negligence Cases in the High Court of Australia,“ in Michael Bryan (ed), *Private Law in Theory and Practice*, Routledge-Cavendish, Oxford, 2007), 55.

<sup>33</sup> A. Beever, *Rediscovering the Law of Negligence* (Hart Publishing, Oxford, 2007), 3.

High Court rejects any attempts to differentiate between public policy and legal policy,<sup>34</sup> Cane specifically sets up a distinction between the two.<sup>35</sup>

The clearest point of agreement that comes out of this debate is that both policy and principle have a legitimate role to play in the judicial decision-making process. The law, as pointed out by Frank over 60 years ago,<sup>36</sup> 'is not a machine and the judges are not machine-tenders'<sup>37</sup> and it is dealing with 'human relations in their most complicated aspects. The whole confused, shifting helter-skelter of life parades before it.'<sup>38</sup> In short, the very nature of the issues that come before the Courts call for a willingness to be flexible and to perhaps apply a clear mix of fixed legal principle and the more loosely defined considerations collectively labelled policy. This is a process we have seen applied with a liberal hand in the causation stage of the 'informed consent' decisions.

It would be easy to become mired in the principle/policy debate, and it is difficult to emerge from such an activity with any clarity. Perhaps it is best to accept that as concepts, they are both difficult to define but undeniably have a role to play in the 'informed consent' cases. Indeed, it may well be that 'the best route to enduring principle ... [lies] through policy.'<sup>39</sup> Accepting this reality does not, however, accept the current use of the term policy to veil individual judicial opinions of what is just and right. To base judicial conclusions upon individual statements of 'broad values ... [may well be] beguiling'<sup>40</sup> but is 'misleading simplicity'<sup>41</sup> and unlikely to result in the development of coherent law.

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<sup>34</sup> *Cattanach v Melchior* (2003) 215 CLR 1, [70] (McHugh and Gummow JJ), referring to a distinction made by Lord Millet in *McFarlane v Tayside Health Board* [2000] 2 AC 59, 108.

<sup>35</sup> P. Cane, „Another Failed Sterilisation“ (2004) 120 *Law Quarterly Review* 189, 192.

<sup>36</sup> Jerome Frank, *Law and the Modern Mind* (Stevens & Sons Ltd, London, 1949).

<sup>37</sup> *Ibid*, 120.

<sup>38</sup> *Ibid*, 6.

<sup>39</sup> *Bazley v Curry* [1999] 2 SCR 534, 551 (McLachlin J).

<sup>40</sup> *Cattanach v Melchior* (2003) 215 CLR 1, [77] (McHugh and Gummow JJ).

<sup>41</sup> *Ibid*.

### *Seeking coherence*

[9.50] The problem at the heart of the policy/principle debate is a lack of coherence and transparency. The judges employ the term policy, in the words of McHugh and Gummow JJ, 'glide to a conclusion,'<sup>42</sup> based upon individually-formed assumptions of what is appropriate in the circumstances. This occurs when the chaos of human relations collides with apparently rigid legal principles. In my view, policy serves to mask the true nature of judicial reasoning and leads to poorly formed law. Stapleton on the other hand, questions the existence of a 'meaningful tension between principle and policy'<sup>43</sup> and suggests that it is 'so-called "principles" often simply masks the substance of a judge's reasoning process.'<sup>44</sup> Clearly there is a conflict of views regarding the source of the problem but the overarching concern remains the same: either principle or policy is acting as a veil over the true nature of judicial reasoning, resulting in a lack of transparency and, potentially, an incoherent development of the law.

Whilst it is easy to refer simply to the notion of 'policy,' it is difficult to give it specific content. As pointed out by Bennion, 'the content of public policy (and therefore legal policy) is what the Court thinks and says it is.'<sup>45</sup> In the absence of clear (and consistent) content, how can reasoning based upon policy provide clarity or certainty in the law? To appeal to policy is potentially to appeal to uncertain and individual notions of what is a fair result in the specific circumstances before the Court, such an appeal represents a departure from 'the path of merely logical deduction ... [and we] lose the illusion of certainty.'<sup>46</sup> It is from certainty and consistency that confidence in the law grows.

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<sup>42</sup> Ibid.

<sup>43</sup> Stapleton, above n.28, 135.

<sup>44</sup> Ibid, 136.

<sup>45</sup> F. A.R. Bennion, *Statutory Interpretation: A Code*, (4<sup>th</sup> ed, Butterworths, London, 1997), 657.

<sup>46</sup> Oliver Wendell Holmes Jr., „Privilege, Malice and Intent,“ (1894-1895) 8 *Harvard Law Review* 1, 7.

It is important to recognise that a call for certainty does not connote a call for a concrete or inflexible law. Indeed the law must, as argued above, remain inherently flexible as it is not (and ought not be) a machine.<sup>47</sup> Flexibility however, does not necessarily lead to incoherent or opaque (as opposed to transparent) law. Rather it means a system that is able to shift and change as needs and expectations of society shift and change. This is particularly important in the context of the consent decisions which take place against the ever shifting background of medical treatment. As argued in this thesis, the conceptual shift to informed choice would represent a move towards coherence and would facilitate a clarity of judicial reasoning that is not present in the appeals to policy.

The law must evolve and change, and this evolution and change must also be acknowledged. To appeal to 'policy' as though it were a concrete and fixed notion (or, as Stapleton argues, to appeal to principle in the same terms) is to deny the nature of the law and to conceal the true nature of the reasoning process underlying the decision. The problem here is more than a mere linguistic difference between principle and policy, it lies in the absence of clear reasoning. As explained by Kirby J in *Cattanach v Melchior*<sup>48</sup> 'if the application of ordinary legal principles is to be denied on the basis of public policy, it is essential that such policy be spelt out so as to be susceptible of analysis and criticism.'<sup>49</sup> Flexibility of the law is not something to hide; it is important that we acknowledge that the process of judicial decision-making is more than a mechanical application of rules.<sup>50</sup> Frank takes this argument further and argues that we ought openly to acknowledge the flexibility, embrace the 'unavoidably human, fallible character of the law,' and if we do this, then perhaps the 'retreat into policy,' may not be necessary.<sup>51</sup> The result would be a far more coherent development of the law and a recognition of

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<sup>47</sup> Frank, above n.36.

<sup>48</sup> (2003) 215 CLR 1.

<sup>49</sup> *Ibid*, [152] (Kirby J).

<sup>50</sup> *Ibid*, 121.

<sup>51</sup> *Ibid*, 2.

the true issues which lay at the heart of the decision. To acknowledge choice, as opposed to consent, as the central concern would further facilitate this.

Turning specifically to the 'informed consent' decisions, there is a clear gap between the identified negligent act (failure to warn of a specific risk) and the manifestation of the risk, which occurs independently of the poor advice. The legally relevant harm arises not from the poor advice, but from the (usually) well-performed procedure. There is a disjunct between the wrong and the apparent loss or injury (or damage) and it is in this gap that the judges flounder and make loose reference to what 'ought' to happen and to policy.

When a doctor fails to inform the patient of the risks involved in a particular course of treatment (or indeed, of not following a particular course of treatment), they have failed to appropriately advise that patient. The subsequent decision to undergo the treatment rests on a flawed foundation: the patient is not aware of all of the possibilities and they have a belief that they will be healed. Neither is the patient able to begin the process of coming to terms with the reality of their condition. This is not true autonomy.<sup>52</sup>

The patient proceeds with the recommended course of treatment which is conducted with all due care and diligence. Sadly, the risk manifests and this is deemed to be the loss. This loss clearly did not flow directly from the wrong that was committed; the provision of advice did not impact on the likelihood of the risk materialising. The gap between the negligent advice and the harm suffered can lead to flawed reasoning. Without resort to 'policy,' the outcome is often a conclusion that, the risk was so small, the illness so big and the trust in the doctor so strong that the patient would have undertaken the treatment even if the advice were given. The very nature of the enquiry, turning as it does on consent and the manifestation of a physical harm, means that 'justice' cannot be done. This in turn results in conclusions such as those

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<sup>52</sup> A term which in itself, poses a significant problem (and is discussed further in Chapter 10).

reached by Lord Steyn in *Chester v Afshar*<sup>53</sup> when he recognised that the decision could not be ‘accommodated in conventional causation principles’ but that ‘policy and corrective justice pull powerfully in favour of vindicating the patient’s right to know.’<sup>54</sup> He then concluded that whilst Ms Chester’s case failed to meet the requisite legal test, she ought to recover so she would recover. This cannot be described as a coherent development of the law and can only result in a lack of confidence in a legal system that asserts that something ‘ought to be so’ and therefore it is.

Appeals to policy can aid in the attainment of a conclusion that an individual judge views as appropriate. This becomes even more problematic when the decision is later given precedential value and applied in entirely different circumstances. An example can be found in the pivotal decisions of *Bolam* and *Sidaway*<sup>55</sup> which both refer to the ‘policy’ of the social utility of medical treatment. Both of these decisions are dependent on a policy formed at a time when medical developments were neither as carefully scrutinised nor monitored<sup>56</sup> as they are today. As pointed out in Chapter 3,<sup>57</sup> subsequent judicial interpretations of these decisions have resiled from questions of policy and have failed to openly acknowledge the significance of policy considerations. The reasoning of these later decisions has been couched in strict legal terms referring to the prudent professional, and this has now been given legislative voice here in Australia.<sup>58</sup> Thus the policy of legal deference to the social utility of medical treatment and the difficulty in determining the appropriate standard of care against the backdrop of this policy, which became the foundation of both the *Bolam* and *Sidaway* conclusions, in turn become the foundation of later decisions. These later decisions are, as a matter of practical reality, from different times and different eras, and failed

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<sup>53</sup> [2005] 1 AC 134.

<sup>54</sup> *Ibid*, [24].

<sup>55</sup> *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 and *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudslsey Hospital and Ors* [1984] QB 493.

<sup>56</sup> By the Courts, the medical profession or, indeed, society.

<sup>57</sup> See in particular the discussion under „The Courts: Putting a gloss on the professional standard test“.

<sup>58</sup> *Civil Liability Act 2002* (NSW) s50, *Civil Liability Act 2003* (Qld) s22, *Civil Liability Act 1936* (SA) s41, *Civil Liability Act 2002* (Tas) s22, *Wrongs Act 1958* (Vic) s59, *Civil Liability Act 2002* (WA) s5PB.



to acknowledge the relevant (or perhaps now irrelevant) policy concerns that lay beneath the original judicial reasoning.

The problem is therefore a multi-layered one. We begin with a flawed enquiry which relies on an illogical link between the negligent act of giving poor advice and the legally relevant (but logically irrelevant) harm suffered. The poorly framed nature of this enquiry causes the judges to struggle to fit their reasoning within accepted negligence principles, resulting in broadly framed appeals to policy. The notion of policy, as used by the judges, lacks clear or consistent content which means that the process of judicial decision-making lacks transparency. As we have seen this is particularly problematic in the context of causation. It is a problem that could be overcome if the judicial focus was on the dignitary harm of loss of choice as opposed to the unrelated physical harm arising as a result of competently performed surgery.

### **A subjective or objective test: Is there any practical difference?**

[9.60] The judicial approach to causation in the 'informed consent' decisions is not solely reliant on questions of policy. Indeed, there is an ongoing endeavour to establish a coherent and principled test based upon either subjective or objective considerations. This does not, however, provide a solution or clarify the process and causation consistently provides the most significant hurdle to the plaintiff, whether the test employed is subjective or objective. An illustrative comparison is between the Australian decision of *Bustos*<sup>59</sup> and United States decision of *Dixon*.<sup>60</sup> Both cases addressed the question of informed consent in the context of a failed juri flap procedure. In *Bustos*, the plaintiff failed because of his subjective attachment to his vision of a new and improved self. In *Dixon* the plaintiff failed because the reasonable

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<sup>59</sup> *Bustos v Hair Transplant* Unrep, NSWCA, 15 April 1997.

<sup>60</sup> *Dixon v Peters* 306 S.E. 2d 477 (1983).

person in his position (that is, a person who is seeking cosmetic surgery) would be focused on the outcome and vision of a new and improved self and would therefore have proceeded. These are purportedly different tests, significantly similar approaches and exactly the same outcome - a disappointed plaintiff.

Causation is a difficult area of the law. As Gaudron J explained in *Chappel v Hart*,<sup>61</sup> 'questions of causation are not answered in a legal vacuum. Rather, they are answered in the legal framework in which they arise.'<sup>62</sup> As Her Honour went on to explain, 'for present purposes that framework is the law of negligence'<sup>63</sup> and negligence demands a clear link between the breach of duty and the harm suffered. Clearly then there is an expectation of a logical link between cause and effect, and the test as stated suggests a straightforward enquiry. As the preceding discussion has demonstrated, however, the enquiry is neither straightforward nor logical. It is my position that the unnecessary complexity of the causation enquiry arises out of the impossibility of the task set before the Courts, and the need to link the denial of a right to information with the manifestation of a physical harm. The plaintiff is currently forced to focus their energies on (and seek recompense for) a physical harm when their concern primarily rises out of the withholding of information and disempowerment of them as an individual chooser.

The problematic nature of the current approach and focus on a link between a dignitary and a physical harm was discussed by Mendelson when she argued that: '[T]here is a long bow between being negligently deprived of the right to make informed decisions (which is not regarded as actionable damage in negligence) and compensation for physical damage which arises from ...

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<sup>61</sup> (1998) 195 CLR 232.

<sup>62</sup> *Chappel v Hart* (1998) 195 CLR 232, [7] (Gaudron J).

<sup>63</sup> *Ibid.*

random and rare complications.’<sup>64</sup> Mendelson succinctly summarised the problem at the heart of the ‘informed consent’ doctrine as it currently exists and pointed to the failing of the continued search for a non-existent link between two completely different kinds of harm. It would be simpler to step back from the physical harm and give the right to make informed decisions the same level of respect it is accorded at the breach stage of the enquiry. It is the denial of this right that would support the proposed doctrine of informed choice.

It is clear that each jurisdiction recognises the individual right to consent (or not) to a risk. Equally clear is the perceived role of the autonomous individual. In every jurisdiction the law ‘start[s] with the premise of thoroughgoing self-determination’<sup>65</sup> but this does not flow through to the causative enquiry. The question of causation is a truly vexed one which has, as we have seen, troubled the Courts. In reality, and on a practical level it is not truly that difficult; it has simply been made that way. The negligent act itself (the failure to adequately inform a patient) is of such an entirely different nature from the actual injury (a physical loss), that a causative link proves elusive. There is advice, followed by a course of treatment which has a poor outcome. The treatment itself is not negligently performed, and in most instances, the recommendation that the treatment be undertaken was not, in itself, negligent. The true concern lies in the denial of choice, and it is at the point of this denial that the true injury occurs. Once this is recognised, then the foundational ideal of patient autonomy will be met.

## Sally

[9.70] Before leaving the causation discussion entirely, let us briefly return to Sally and see whether she could recover in any of the jurisdictions under

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<sup>64</sup> D. Mendelson, ‘The Breach of the Medical Duty to Warn and Causation: *Chappel v Hart* and the Necessity to Reconsider Some Aspects of *Rogers v Whitaker*’ (1998) 5 *Journal of Law and Medicine* 312, 314.

<sup>65</sup> *Scott v Bradford* 606 P.2d 554 (1980), 556 (Doolin J).

consideration, and of course consider whether or not there is any practical difference between the objective and subjective tests. Sally's story is set out in Chapter 5 and the relevant key points are: her age (20 years old) and the long history she had with her doctor. Her degenerative eye disease, if left untreated, was certain to result in blindness within 5 years and the best suggested treatment had to offer was a slowing down of the degeneration and perhaps an additional 5 years of sight. The treatment carried a small chance of immediate onset of blindness and Sally's doctor chose not to tell her of this risk as he felt that it would only serve to alarm her. Duty and breach were clear and straightforward in all three jurisdictions. Whether the Court chose to apply a patient or professional measure of the standard of care it was easy to determine what Sally ought to have been told. This does not, however, translate into liability and we will see that the very nature of the relationship between Sally and her doctor, the trust and reliance upon which the therapeutic relationship is built, would undermine her claim.

In the United Kingdom the predominant test, as enunciated in *Smith v Barking, Havering & Brentwood Health Authority*<sup>66</sup> is subjective in nature and based upon the particular patient. The subjective test is, however, tempered by objective consideration of what the reasonable plaintiff, in that position, would have done.<sup>67</sup> A similar approach has been adopted here in Australia and the test, as explained by McHugh J begins as a subjective test but questions of 'what a reasonable person would or would not have done in the patients' circumstances will almost always be the most important factor.'<sup>68</sup> Thus both jurisdictions begin with the individual patient assertions of what they would or would not have done and temper this with considerations of what a reasonable person in their position would (or would not) have done.

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<sup>66</sup> [1994] 5 Med L.R. 285.

<sup>67</sup> Ibid, 289 (Hutchinson J).

<sup>68</sup> *Rosenberg v Percival* (2001) 205 CLR 434, [24] (McHugh J).

If we begin with the subjective considerations, of course Sally would claim that she would not have had the operation. She would however have had to admit the long and trusted nature of the relationship between her and the doctor and the desperate nature of her condition (in the absence of any treatment she would be blind within 5 years). On a purely subjective basis, it would be difficult to accept any assertion by Sally that she would not have been prepared to take the risk that she may suffer immediate loss of sight. This position would of course be cemented by the application of objective factors which include, *inter alia*, assessment of the patient's character and personality, the slight risk of harm (1 in 14,000) and this procedure being the most likely to produce the best results.<sup>69</sup> Sally would not be able to point to a link between the failure to provide her with sufficient information and the immediate onset of blindness.

The position in the United States would not be any different. In the majority of jurisdictions the Courts would begin with the objective test and ask what would a reasonable patient in Sally's position do? Clearly, a reasonable 20 year old who trusts her doctor implicitly would balance the small risk of immediate onset of blindness and the chance of a slowing down of the degeneration of her sight against the certainty of complete loss of sight in 5 years, and consent to the treatment.

In all three jurisdictions it is clear that Sally would fail to recover. But are the Courts asking the right question? This thesis asserts that no, the question as it stands is incorrect. Of course Sally would have proceeded with the treatment, there is no hint of trespass here. However, this is not addressing the question of whether or not she was able to truly exercise her autonomous decision-making authority. In the absence of a clear causative link the Courts could choose to adopt the *Chester*<sup>70</sup> approach and conclude that she ought to

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<sup>69</sup> These were the objective factors listed by McHugh J in *Rosenberg v Percival* (2001) 205 CLR 434, [31], see also Gummow J [87].

<sup>70</sup> *Chester v Afshar* [2005] 1 AC 134.

recover, and therefore she will. Alternatively, the decision could be based on a statement of 'values' enabling the Court to 'glide to a conclusion'<sup>71</sup> thus acknowledging the 'wrong' that was done to Sally. Whilst superficially achieving 'justice' for the Sally such an approach would not accord with well-established negligence principles and would only serve to undermine the credibility of the law. The inability of the Courts to adequately address this was given some recognition in the decision of *Smith v Barking, Havering & Brentwood Health Authority*<sup>72</sup> when the plaintiff, in a similarly reliant relationship, was not informed of the small risk of immediate onset of tetraplegia. Here the Court awarded her damages for the shock and depression arising from the surprise at the immediate deterioration of her condition. At no point however is the foundational ideal of autonomy addressed and the right to make a meaningful choice and begin to address the reality of her condition is overlooked. To award damages for the result of this is to merely apply a judicial band-aid and fails to ask the correct question. In order to adequately address what is occurring in the pre-treatment advice decisions the Courts must be permitted to cease their ongoing struggle with consent and embrace the concept of choice.

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<sup>71</sup> *Cattanach v Melchior* (2003) 215 CLR 1, [77](McHugh and Gummow JJ).

<sup>72</sup> [1994] 5 Med L.R. 285.

## PART III: THE WAY FORWARD - A NEW MODEL OF LOSS

To say that every patient must provide informed consent to all medical treatment is a deceptively simple statement. Its basic premise is that we are autonomous individuals with certain fundamental rights and if these rights are denied, we have suffered a loss and ought to be able to seek recompense under the law. Once again, this is a fairly straightforward statement, easy to accept but, when one looks behind the simplicity of the words, layer upon layer of questions arise: if it is so straightforward, why (as demonstrated in Parts I and II) have the Courts struggled with the concept? Does the doctrine of informed consent turn on professional standards or patient expectations? How can we have a situation, as demonstrated in earlier Chapters, of the Courts stating that this is not about consent and then later Courts relying on these earlier decisions to support the 'doctrine of informed consent?' If the discussion is all about autonomy, what is autonomy? And finally, is the enquiry even about consent? Inherent in all of these questions is the broader one of whether we should be shifting our focus away from 'informed consent' towards a concept of 'informed choice' thus achieving the goal of the High Court to infuse choice with meaning.<sup>1</sup>

This thesis has explored the development of the doctrine of 'informed consent' and challenged the unwavering acceptance of the theme of consent. Parts I and II tracked the development of the current doctrine across three jurisdictions and asserted that whilst there are some semantic differences between the tests, the basic process is the same with the outcome favouring

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<sup>1</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 489, (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ) distinguish consent from meaningful choice, pointing to consent as being relevant to trespass and explaining that „meaningless consent“ (that is consent based on insufficient information) can defeat a trespass claim. It follows therefore that the doctrine of „informed consent“ is not about trespass and consent but about ensuring that doctors provide the patient with sufficient information to enable a meaningful choice.

the defendant. It is from this discussion that the core themes of autonomy and choice are drawn. At the heart of this thesis sits a recognition of the significance of autonomy and a challenge to the language of consent when addressing the provision of pre-treatment advice. Part III will draw the threads of the preceding discussion together and move towards a conclusion involving the adoption of a more precise definition of autonomy and recognition of the role of choice. This represents a shift away from issues of 'consent' and the problematic nature of importing trespassory notions into the negligence framework. The creation of a model of loss based upon choice serves to empower the patient as a self-authoring participant in the treatment process and meets the foundational principle of autonomy.



## Chapter 10: Autonomy - Defining the Undefined

### Autonomy: Do we know who the autonomous individual is?

[10.10] The doctrine of ‘informed consent’ rests on the notion of autonomy. This identification of autonomy as a fundamental principle was present in the earliest decisions regarding advice prior to treatment. Despite its characterisation as a trespass decision, the *Schloendorff* principle that ‘every human being of adult years and sound mind has a right to determine what shall be done with his own body’<sup>1</sup> has been described as ‘germinal.’<sup>2</sup> The language of *Schloendorff* was adopted by Lord Steyn in *Chester v Afshar*,<sup>3</sup> and closer to home, Kirby J described the *Schloendorff* rationale as ‘fundamental to the formulation adopted by this Court in *Rogers v Whitaker*.’<sup>4</sup> A similar theme is found in the scholarly literature where it has been suggested that the ‘purpose of [the rules about informed consent] is to permit the patient the continued exercise of self-determination or autonomy.’<sup>5</sup> More broadly, protection of the autonomous individual has been described as ‘the dominant rhetorical value in ... medical law and ethics,’<sup>6</sup> and autonomy, in the context of bioethics, has been described as ‘something of a religion.’<sup>7</sup>

Thus autonomy is clearly a ‘fundamental value’ in discussions involving pre-treatment advice,<sup>8</sup> yet rarely is there any attempt to provide a purpose-specific definition of the term. It is one thing to make sweeping appeals to autonomy or self-determination but another thing entirely to define and

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<sup>1</sup> *Schloendorff v Society of New York Hospital* 105 NE (1914) 92, 93 (Cardozo J).

<sup>2</sup> *Retkwa v Orentreich* 154 Misc. 2d ed 164 (1992), 166-167 (Kristin Booth Glen J).

<sup>3</sup> *Chester v Afshar* [2005] 1 AC 134, [14] (Lord Steyn).

<sup>4</sup> *Rosenberg v Percival* (2001) 205 CLR 434, [142] (Kirby J, referring to *Rogers v Whitaker* (1992) 175 CLR 479).

<sup>5</sup> S.A.M. McLean, *A patient's right to know: Information disclosure, the doctor and the law* (Dartmouth Publishing Company, Aldershot, 1989), 80.

<sup>6</sup> Roger B. Dworkin, „Medical Law and Ethics in the Post-Autonomy Age“ (1992-1993) 68 *Indiana Law Journal* 727, 727.

<sup>7</sup> J.Coggon, „Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?“ (2007) 15 *Health Care Analysis* 235, 236.

<sup>8</sup> McLean, above n. 5, 90.

successfully protect it. MacLean has noted that 'in an ideal world, judges would use the law to reinforce the value of patient autonomy'<sup>9</sup> but has lamented that this aspiration is not reflected in the legal reality. She affirms that 'the law of consent is unable to take meaningful account of the concept of autonomy.'<sup>10</sup> I suggest that this gap between aspiration and reality is due to the failure define autonomy. The reality is that claims regarding the need to protect autonomy are 'sometimes made with little thought as to the nature of the right [to autonomy] itself'<sup>11</sup> and in the absence of a definition autonomy lacks content. As it stands, judicial ruminations on the level of information that the autonomous individual ought to receive do not extend to a consideration of who, or what, is the autonomous individual. The central character of the consent enquiry is therefore insubstantial and poorly defined.

The law is a creature of definition and linguistic subtleties; indeed many legal decisions turn on the definition of specific words or phrases. It is therefore curious that autonomy, which is central to the doctrine of 'informed consent', is so ill-defined. Of course it is important to remember that the role of the judge is to interpret and apply the law and, as such, it would perhaps be inappropriate for judicial consideration of medical advice to include an in-depth exploration of abstract notions such as autonomy. Indeed, such an exploration might well draw criticism that judges are 'employed to judge the law and not questions of ethics.'<sup>12</sup> However, the ongoing reference to self-determination and autonomy in the absence of specific judicial definition hints at a common understanding of the meaning of the term which therefore does not require articulation. This is not the case. Autonomy has been the

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<sup>9</sup> Sheila A.M McLean, *Autonomy, Consent and the Law* (Routledge-Cavendish, London, 2010), 95.

<sup>10</sup> *Ibid*, 94.

<sup>11</sup> R. Heywood, „Book Review: Autonomy, Consent and the Law“ (2011) 19 *Medical Law Review* 150, 150. It is interesting to note here that Heywood refers to autonomy as a „right“ of itself when it is perhaps more correct to identify that the different „rights“ that recognition of autonomy protects, such as the right to information, make choices and bodily integrity.

<sup>12</sup> Coggon, above n.7, 236.

subject of much scholarly discourse and who (or what) constitutes a truly autonomous individual remains open to debate.<sup>13</sup>

It is clear therefore that 'informed consent' rests upon a poorly-defined concept. The legal effect of the avoidance of the 'full theoretical rigour' of autonomy is that 'potentially the Courts will find themselves defending a concept of unspecific scope or meaning.'<sup>14</sup> Coggon has also suggested that it is 'possible for judges to use the equivocal nature of the concept [of autonomy] to achieve outcomes that they consider to be morally desirable ... rather than simply to apply a single concept to comparable legal questions.'<sup>15</sup> The absence of a clear definition is problematic and if the pre-treatment conversation is to be given meaningful legal protection, then the character sitting at its heart (that is, the autonomous individual) must be clearly and appropriately defined.

Clarification will come with the identification of a non-exhaustive definition of autonomy to be adopted by the judiciary in the context of the provision of pre-treatment advice. This is the goal of this Chapter. Through a brief exploration of the rich scholarship surrounding autonomy it will identify some common themes and will entail a consideration of the central debates surrounding autonomy and identification of the issues at the heart of the debates. From this discussion, I will propose a definition of autonomy which will help the move towards a doctrine of informed choice. The proposed definition of autonomy will provide the basis for Chapter 11 which will consider the nature of consent and identify the true harm sustained when pre-treatment advice is flawed. In drawing these two themes together, I will then suggest a reformulation of the legal test in order to adequately protect autonomy and meet the stated aims of the current, poorly framed, 'informed

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<sup>13</sup> The scholarly debate is considered below: The scholarly debates (at [10.40]).

<sup>14</sup> Ibid, 238.

<sup>15</sup> Ibid, 236.

consent' enquiry. This proposal will require a conceptual shift away from 'informed consent' towards one of 'informed choice.'

### **A principle in search of a definition**

[10.20] Autonomy is a principle in search of a definition. The very essence of autonomy involves a concept of individuality and, as such, can mean different things to different people in different circumstances. Quite aptly it has been described as 'a relatively contentless notion'<sup>16</sup> on the basis that 'the exercise of the capacity of autonomy is what makes my life *mine*.'<sup>17</sup> It is therefore a daunting task to embark on the process of providing a definition that will capture the essence of autonomy and provide the clarity missing from the judicial interrogations of pre-treatment conversations. In constructing a *legal* definition of such a complex term, it is appropriate to begin with a consideration of the dictionaries. Consultation will begin with the common English dictionaries to provide insight into ordinary language usage, then the legal dictionaries will be considered to determine whether there is an accepted legal definition and, finally, the dictionaries of philosophy will be consulted for broad generalisations.

#### *The dictionaries*

[10.30] The dictionary definition of autonomy is relatively straightforward. It is described as 'the right of self-government, personal freedom and freedom of the will,'<sup>18</sup> and 'freedom of the will, freedom of external control or influence. Personal liberty.'<sup>19</sup> Similarly, the *Macquarie Dictionary* defines autonomy as 'self-government, independence, self-sufficiency and self-regulation'<sup>20</sup> and the *Collins English Dictionary* refers to 'the right or state of

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<sup>16</sup> Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge University Press, Cambridge, 1988), 110.

<sup>17</sup> *Ibid*, 111.

<sup>18</sup> *The Oxford Encyclopedic Dictionary* (Clarendon Press, Oxford, 1991).

<sup>19</sup> *The New Shorter Oxford English Dictionary, Volume 1* (Clarendon Press, Oxford, 1993).

<sup>20</sup> *Macquarie Dictionary*, (5th ed, Macquarie Dictionary Publishers, Sydney, 2009).

self-government, freedom to determine one's own actions, behaviour etc ...'<sup>21</sup> Interestingly the last two dictionaries include a reference to the philosophical concept of autonomy, described as: 'the doctrine that the individual human will contains its own principles and laws.'<sup>22</sup> From these definitions emerge the consistent themes of freedom, self-government and exercise of free will. The philosophical dictionaries expand on these themes and the vast body of scholarly work on autonomy endeavours to give them content and meaning.

Autonomy is best characterised as an ethical or philosophical concept and is therefore not defined in the legal dictionaries. But the relevance of autonomy to the law is identified in *The New Oxford Companion to Law*<sup>23</sup> which describes the 'most important task of autonomy' to be the ability to 'argue for a certain ideal of the liberal state: that of neutrality.'<sup>24</sup> There is also a separate heading dedicated to the role of autonomy in the law surrounding consent to treatment. Here the primacy of the principle of autonomy and the corresponding right to refuse treatment are highlighted and discussed in the context of the conflict with the sanctity of life. The discussion further notes that consent to treatment will negative a battery action. The entry also differentiates basic consent to medical treatment from the 'ethical doctrine of informed consent' and then describes the 'legal doctrine' of informed consent but does little to illuminate the role of autonomy,<sup>25</sup> simply offering a basic outline of the law as it stands. The authors also note that 'the fact that different theorists may use the same word should not ... lead one to assume that they are all referring to the same thing ... one has to fashion different concepts in light of the nature of the problems.'<sup>26</sup> In short, the Legal Dictionaries offer the following 'clarification': 'Informed consent' is different from 'consent' and can be described as an ethical doctrine. But 'informed consent' is then defined as a legal doctrine. Further, autonomy does not mean

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<sup>21</sup> *Collins English Dictionary* (2nd ed, Collins, Sydney, 1986).

<sup>22</sup> *Ibid*, and above n.20.

<sup>23</sup> P.Cane and J. Conaghan, ed *The New Oxford Companion to Law* (Oxford University Press, Oxford, 2008).

<sup>24</sup> *Ibid*, 63.

<sup>25</sup> *Ibid*, 202.

<sup>26</sup> *Ibid*, 63.

the same thing to every person but must be fashioned in light of the context under consideration.

Turning then to the Dictionaries of Philosophy, the themes mentioned in the English dictionaries are given closer consideration. The *Penguin Dictionary of Philosophy*<sup>27</sup> refers to autonomy as self-rule and describes the role of autonomy in ethics as 'a person's capacity for self-determination; ability to see oneself as the author of a moral law by which one is bound.'<sup>28</sup> The definition here includes reference to the view held by some philosophers that autonomy is a synonym for 'logical or conceptual independence.'<sup>29</sup>

The *Oxford Companion to Philosophy*<sup>30</sup> expands on the Kantian notion of morality and introduces the 'moral imperative' which is described as a 'moral agent's own freely and rationally adopted moral policy.'<sup>31</sup> Significantly for this discussion, the definition then contains a clear statement regarding the broad variety of concepts of autonomy noting that 'what autonomy amounts to ... has been interpreted in radically different ways.'<sup>32</sup> The ensuing summary of the different conceptions of autonomy includes reference to the notion of 'enacting through common rational procedures,' 'individual sovereignty over his or her choice of moral values and self-construction' and there is also reference to the importance of autonomy in the relations between the patient and the medical practitioner (but there is no attempt to specifically define autonomy in this context).<sup>33</sup> The essence of autonomy in this particular definition is then summarised as being 'more than just the capacity

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<sup>27</sup> *Penguin Dictionary of Philosophy* (2<sup>nd</sup> ed, Penguin, Melbourne, 2005).

<sup>28</sup> *Ibid.* The ideal of a „moral law“ draws upon the work of Kant (to be discussed further below, see: The scholarly debates at [10.40]).

<sup>29</sup> *Ibid.*

<sup>30</sup> T. Honderich (ed), *The Oxford Companion to Philosophy* (Oxford University Press, Oxford, 1995).

<sup>31</sup> *Ibid.*, 69.

<sup>32</sup> *Ibid.*

<sup>33</sup> *Ibid.*, 69-70.

to act on particular desires or choices ... it is a more general capacity to be self-determining, to be in control of one's own life.'<sup>34</sup>

This brief perusal of the dictionaries may well leave one with the impression that autonomy defies definition, but this is not the case. Certain concepts and themes are common to all of the discussions. These include liberty and/or freedom, choice and the primacy of self-governance. This of course opens the door to further, more complex debate regarding the nature of choice,<sup>35</sup> the scope of individual freedom or liberty and of course, how we define 'self.' The remainder of this Chapter will provide some insight into the bioethical and philosophical debates regarding these issues and will draw out common themes with the ultimate goal being a clarification of the concept of autonomy and how it can be precisely and simply defined in the context of the provision of pre-treatment advice.

### **The scholarly debates**

[10.40] At the outset it is important to recognise that the breadth of scholarly discourse on autonomy is enormous and it is well beyond the scope of this thesis to provide a comprehensive overview of that discourse. This is not a philosophical discussion; it is one based on legal issues. The focus of the analysis is on the nature of a legal doctrine and the aim is to identify a way in which that doctrine can most successfully achieve the fundamental goal of protecting the autonomy of patients. The aim of this part of the analysis is to emphasise the diversity of interpretations of the term 'autonomy' and to draw out common threads or themes. Once these common threads are identified it will be possible to identify a precise, easily-understood definition

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<sup>34</sup> Ibid, 70. *The Cambridge Dictionary of Philosophy* (Cambridge University Press, Cambridge, 1996), introduces similar concepts but does not have a single entry for autonomy, referring instead to the free will problem, Kant and negative freedom.

<sup>35</sup> To be explored further in Chapter 11.

of autonomy that can serve the purpose of 'informed consent'<sup>36</sup> and empower the patient as the decision-maker.

Before considering the definition of autonomy, it is worth asking why is it so important? What interests lie at the heart of the autonomy debate and, indeed, why has the debate been so extensive? It has been suggested that the 'literature of biomedical ethics ... [rests on] ... assumptions that autonomy should be protected,'<sup>37</sup> and the same can be said of the legal discussions which point to autonomy as a foundational principle warranting legal protection. There are also claims of the 'triumph of autonomy'<sup>38</sup> which hint at concerns regarding the primacy of the autonomous individual. Underlying all of these discussions, however, is an acceptance of the significance of autonomy and the need to provide ethical and legal protection of the autonomous decision-maker. Humans are regarded as a complex mix of social and individual beings. Or, as Christman succinctly explains, 'the autonomous person has certain fundamental interests which principles of justice are designed to protect.'<sup>39</sup> The key to successful protection is to find and enunciate those interests and principles in a meaningful way.

This Chapter opened with a consideration of the linguistic and philosophical definitions of autonomy and three themes emerged from this discussion: choice, freedom (or liberty) and self-definition. Choice is considered in Chapter 11 where I will continue to challenge the appropriateness of the label 'informed consent.' The other two themes, the concept of freedom or liberty and the ability to define one's self, will be the focus of the remainder of this Chapter which will provide a broad overview of the scholarly literature of autonomy. This discussion will bring us closer to an acceptable definition of autonomy that can provide a sound basis for the judicial consideration of pre-

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<sup>36</sup> Remodelled by this thesis to informed choice.

<sup>37</sup> Lawrence Haworth, *Autonomy*, (Yale University Press, London, 1986), 5.

<sup>38</sup> C.E. Schneider, *The Practice of Autonomy: patients, doctors and medical decisions* (Oxford University Press, New York, 1998), xi.

<sup>39</sup> J. Christman, „Relational Autonomy, Liberal Individualism and the Social Constitution of Selves“ (2004) 117 *Philosophical Studies* 143, 147.



treatment advice. These two Chapters will then be drawn together in the final recommendation of this thesis which is the conceptual shift from a doctrine of 'informed consent' to one of 'informed choice' and will include a non-exhaustive definition of autonomy that will facilitate this shift.

### *Freedom and/or liberty*

[10.50] Liberty is a fundamental component of autonomy. Throughout the literature it is either referred to alongside of, or at times, as synonymous with, autonomy. Indeed, it could be said that the ultimate expression of autonomy is individual freedom. But what is the nature of this freedom (or liberty) and are there any limits imposed on personal liberty? Can autonomy exist in the absence of unfettered liberty? Different authors would answer this question in different ways. A useful summary is found in the work of Gerald Dworkin where he describes the different ideas of 'persons as self determining' yet suggests that at an abstract level, the different models hold the same concept of autonomy.<sup>40</sup> In his words:

Josiah Royce speaks of a person as a life led according to a plan. Marxists speak of man as the creature who makes himself; existentialists of a being whose being is always in question; Kantians of persons making law for themselves.<sup>41</sup>

Different scholars therefore view the essence and expression of individuality in different, and potentially contradictory ways, yet hold a common view that individuality 'functions as a moral, political and social ideal,'<sup>42</sup> and is something that ought to be left 'independent and unmanipulated.'<sup>43</sup> Thus we see a view of an individual in the centre of their world, being permitted to define themselves with the fundamental freedom to do and be as they will.

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<sup>40</sup> Gerald Dworkin, above n.16, 10.

<sup>41</sup> Ibid, 9.

<sup>42</sup> Ibid, 10.

<sup>43</sup> Ibid, 11.

In Dworkin's work, we see the emergence of liberty and the individual but we are not seeing a definition of the nature of liberty. Its importance is undeniable, but its nature and limits remain unexplored. Guidance and insight can be found in the work of the earlier, and extremely influential thinker, John Stuart Mill.

Mill's famous essay, *On Liberty* is not limited to a consideration of autonomy; it also considers the interaction of the individual with society, suggesting that the essence of a healthy society is a collection of healthy individuals. In Mill's treatise, the essence of autonomy (or individuality<sup>44</sup>) is closely linked with liberty. Some core principles can therefore be borrowed from Mill when endeavouring to identify the nature of autonomy (for legal purposes) and the relationship between autonomy and liberty.

In Mill's view, individuality as an expression of autonomy is the essential ingredient of a healthy society. To enrich and empower the individual is to enrich and empower society: 'In proportion to the development of his individuality, each person becomes more valuable to himself and is therefore, capable of being more valuable to others.'<sup>45</sup> Thus, it is essential that different persons should be allowed to lead different lives.<sup>46</sup> The liberty and freedom of individuals is the key to healthy individuals and thus a healthy society. To Mill, the only possible rationale for interfering with the liberty of one person is to prevent them from harming another.<sup>47</sup> In short, 'over himself, over his own body and mind, the individual is sovereign.'<sup>48</sup> This is a theme which echoes throughout the literature and overflows into the law.

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<sup>44</sup> J.S. Mill more commonly referred to individuality than autonomy but it was clear that he was considering similar themes and rights.

<sup>45</sup> J.S. Mill, *On Liberty* in J. Troyer, ed *The Classical Utilitarians Bentham and Mill* (Hackett Publishing Inc, Cambridge, 2003), 199.

<sup>46</sup> *Ibid.*

<sup>47</sup> *Ibid.*, 158.

<sup>48</sup> *Ibid.*

Turning now to Roger Dworkin,<sup>49</sup> we see freedom described as ‘the cardinal, absolute requirement of self-respect.’<sup>50</sup> It is Dworkin’s position that the ‘intrinsic and objective importance’ of one’s own life can only arise when the individual is free to lead ‘that life himself’ as opposed to being ‘ushered along it by others.’<sup>51</sup> Similarly, the celebrated liberal scholar Isaiah Berlin places liberty alongside autonomy and emphasises the central importance of both concepts.<sup>52</sup> He claims that freedom is given substance by the ‘degree to which no man or body of men interferes with my body’<sup>53</sup> yet describes it as ‘a term so porous that there is little interpretation that it seems able to resist.’<sup>54</sup> We are once again left with a concept that is undeniably central to the individual but open to interpretation and, according to Berlin, so ‘or porous’ that it can be adapted for any purpose. How then can it provide a consistent basis for a legal doctrine?

Berlin does, however, explore the concept of liberty further and draws out similarities between the theories which mean that both autonomy and liberty can be given substance and form. He draws on ‘libertarians such as Locke and Mill’ who believed that ‘there ought to be a minimum area of personal freedom which must on no account be violated’<sup>55</sup> and modern Western liberals who believe that ‘individual liberty is an ultimate end for human beings.’<sup>56</sup> Liberty is also central to the work of Kant, but his version of liberty is different again. To Berlin, Kant’s position is that liberty is expressed ‘not through the elimination of desires but with resistance to them and control over them,’<sup>57</sup> as opposed to the ‘libertarian’ view that the embracing of desires and wishes is the embodiment of freedom. Gerald Dworkin offers further insight into the Kantian position which he describes as viewing

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<sup>49</sup> Roger Dworkin, above n.6.

<sup>50</sup> *Ibid*, 239.

<sup>51</sup> *Ibid*.

<sup>52</sup> I. Berlin *Four Essays on Liberty* (Oxford University Press, London, 1969), 121.

<sup>53</sup> *Ibid*, 122.

<sup>54</sup> *Ibid*, 121.

<sup>55</sup> *Ibid*, 124.

<sup>56</sup> *Ibid*, 125.

<sup>57</sup> *Ibid*, 137.

‘moral autonomy [as] a combination of freedom and responsibility: it is a submission to laws that one has made for oneself.’<sup>58</sup> Thus freedom, liberty and autonomy are open to a variety of interpretations but there is a constant thread of individuality and respect for individuality. As Berlin suggests, ‘whatever the view of the world and society there is one constant, some portion of man’s existence must remain independent ... [that which] a man cannot give up without offending against the essence of his human nature.’<sup>59</sup> The question then becomes, how do we identify what it is that ‘man’ cannot give up and how can these diverse theories inform the law so as to ensure that core principle is accorded due respect? We will return to this question after considering the struggle to define the nature of the individual.

### *Defining one’s self*

[10.60] The preceding discussion reveals that while liberty and freedom are aligned with autonomy, the concept of autonomy is richer and broader than liberty,<sup>60</sup> and that richness comes from the perceived nature of the individual. It may appear tautological to refer to the individuality of the individual but what defines each individual is, by its very nature, a personal process which can differ in as many ways as there are people. We are, therefore, dealing with a potentially complex and variable notion and it is in this complexity that the problematic nature of a legally-defined autonomous being becomes more evident. It is important to reiterate here that I am not seeking to identify a broad, all-encompassing definition of autonomy. The aim of this Chapter is more modest: it is to identify a practical, legal definition of autonomy which accords with general views. This definition will take the diverse interpretations of autonomy into account but will not attempt to reconcile them.

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<sup>58</sup> Gerald Dworkin, above n.16, 14.

<sup>59</sup> Berlin, above n.52, 126.

<sup>60</sup> Gerald Dworkin, above n.16, 106.

As Berlin points out, the question of what constitutes an individual has been raised before, but is yet to be definitively answered: 'ever since the issue was raised towards the end of the eighteenth century, what is meant by an individual has been asked persistently and with increasing effect.'<sup>61</sup> But in hinging arguments upon such broad concepts as autonomy without analysing or addressing exactly what we are talking about, there is a tendency to oversimplify the way in which we make decisions and perhaps succumb to the temptation to 'exaggerate the uniformity of human nature and conduct.'<sup>62</sup> This temptation can, however, be avoided if we focus on the process of self-definition as opposed to defining what constitutes an individual. There are readily identifiable similarities in the broad spectrum of the former but few in the latter. Each and every identified individual in the world differs in some material way, thus it is impossible to state that all individuals have the same specific characteristics. It is possible, however, to identify similarities in the manner in which we determine and approach self-definition.

Two clear schools of thought have developed in the scholarly literature on the definition of self: the individualistic model and the relational model. While there are important differences between the two schools of thought, the following (necessarily brief) overview of the relevant literature reveals that Christman was correct when he asserted that 'social and individual conceptions of self are compatible.'<sup>63</sup> A similar view was more recently expressed by McLean when she suggested that 'the purported difference between individualistic and relational autonomy is by no means so great as at first appears,'<sup>64</sup> and 'that the distinction between the two is exaggerated.'<sup>65</sup>

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<sup>61</sup> Berlin, above n.52, 154.

<sup>62</sup> Schneider, above n.38, xvii.

<sup>63</sup> Christman, above n.39, 146. He refers at this point to Mackenzie and Stoljar, "Introduction: Autonomy Reconfigured" in C.Mackenzie and N.Stoljar (eds) *Relational Autonomy: Feminist perspectives on Autonomy, Agency, and the Social Self* (Oxford University Press, New York, 2000), 8 also J. Crittenden, *Beyond Individualism: Reconstituting the Liberal Self*, Chapter 5 in W. Kymlicka, *Liberalism, Community and Culture* (Oxford University Press, Oxford, 1989).

<sup>64</sup> S.A.M McLean, *Autonomy, Consent and the Law* (Routledge-Cavendish, London, 2010), 214.

<sup>65</sup> *Ibid*, 224.

For those who support an individualistic view of autonomy, the process of self-definition is an internal process. The most notable advocate of this view of autonomy is Immanuel Kant who adopted the position that the essence of autonomy is self-determined morality.<sup>66</sup> It was his view that we are 'rational beings who spontaneously impose lawfulness on the world in which we live and thereby create basic order.'<sup>67</sup> The essence of Kant's approach is to treat 'autonomy as a basic condition of moral agency' which involves 'one imposing moral constraints on oneself through one's own reason.'<sup>68</sup> Kant sought to root morality in reason which was an internal as opposed to an external force, completely 'independent of external influences and constraints.'<sup>69</sup> Thus Kant's 'categorical imperative' saw the individual as an isolated creature, created and constrained from within.

This position is in direct contrast to that of the relational autonomists who argue for the inherently social nature of humans and say that we cannot view individuals in isolation; rather they must be viewed and defined within the social and familial frameworks which surround and support them. This view of autonomy was initially associated with feminist scholars<sup>70</sup> but is now more widely embraced and in my view presents a persuasive model of autonomy which acknowledges that individuals exist within a context of experience and relationships.

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<sup>66</sup> See I. Kant, *The Moral Law: Groundwork of the Metaphysics of Morals*, Translated by H.J.Paton (Routledge Classics, London, 2005), 61 in which Kant describes the „aim of the present *Groundwork* is to seek out and establish the *supreme principle of morality*'

<sup>67</sup> J.B. Schneewind, *The Invention of Autonomy: A History of Modern Moral Philosophy* (Cambridge University Press, Cambridge, 1998), 483 and 484.

<sup>68</sup> L.C. Becker (ed) L.C. Becker (assoc ed), *Encyclopedia of Ethics* (Garland publishing Inc, NY, 1992), 71 and 72.

<sup>69</sup> J. Macquarrie (ed) *A Dictionary of Christian Ethics* (SCM Press Ltd, London, 1971), 63.

<sup>70</sup> Christman, above n.39 for example refers us to J.Nedelsky, „Reconceiving Autonomy: Sources, Thoughts and possibilities," (1989) 1 *Yale Journal of Law and Feminism* 7-36, M.Oshana „Personal autonomy and Society" (1998) 29(1) *Journal of Social Philosophy* 81-102 and an overview, the essays in C.Mackenzie and N.Stoljar (eds) *Relational Autonomy: Feminist perspectives on Autonomy, Agency, and the Social Self* (Oxford University Press, New York, 2000). See also McLean, above n.64, 214 who describes relational autonomy as „closely identified with communitarianism and feminism."

The broad view of relational autonomy is that individuals are to be viewed as inherently social and supported by 'natural and social settings.'<sup>71</sup> Christman draws our attention to relational autonomy as 'emphasising the role that background social dynamics and power structures play in the enjoyment and development of autonomy,'<sup>72</sup> and Berlin cautions us that our 'individual self is not something which [we] can detach from [our] relationship with others, or from those attributes of [ourselves] which consist in their attitude towards [us].'<sup>73</sup> Similarly, Atkins reminds the reader that 'my sense of who I am ... cannot be isolated from my social setting or from specific others in relation to whom the question of who I am arises.'<sup>74</sup> Of significance to the relational model of autonomy is the view of identity as something 'dynamic and discursive, a collaboration ... formed through relations with other people.'<sup>75</sup> In short, the very social nature of humanity is fundamental to the process of defining individuals; we are subject to the influences of the world around us and of those who inhabit that world.

While the individualist and relational theories of autonomy provide different insights into the essence of the individual, they do have one fundamental concept in common: the individual at the heart of the debate. At the centre of all of these discussions sits the individual either defined entirely from within, or as a result of their interaction and relationships with others, that is an individual formed as they relate to others. Either way, there is an individual who directs what does, or does not happen to them. They are self-authoring and self-directing. It is to this common thread that I will now turn and identify the most appropriate model of autonomy in the context of pre-treatment advice: narrative autonomy.

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<sup>71</sup> Haworth, above n.37, 14.

<sup>72</sup> Christman, above n.39, 143.

<sup>73</sup> Berlin, above n.52, 156.

<sup>74</sup> Kim Atkins, „Narrative Identity and Embodied Continuity“ in Kim Atkins & Catriona MacKenzie (ed), *Practical Identity and Narrative Agency* (Routledge, New York, 2008), 87.

<sup>75</sup> *Ibid*, 89.

### *A common thread: The individual as storyteller*

[10.70] It is clear therefore that autonomy is a complex ideal. It represents individual freedom to choose and define oneself. Autonomy relies upon theories of individuality and the nature of humanity which, as Christman explains, is 'variable and fluid' meaning that 'self-conceptions (and so "selves") change over time and vary considerably across contexts.'<sup>76</sup> To inject meaning into the legal doctrine of 'informed consent,' therefore, we need to identify the appropriate elements of 'self-conception' and adopt a contextually appropriate definition of autonomy. This is, surprisingly, quite easy to do.

Whatever view of self-definition, freedom, liberty, self-determination, individuality (to list just a few of the relevant labels) is adopted by scholars, there remains one constant, and that is the view of the individual as a self-directing or self-authoring being. The differences in theories spring from the view of the relevant influences that act upon that individual and identification of any possible limitations on individual authority. In the idea of the individual as author of his or her own life, however, we begin to identify a model of autonomy which can be readily understood and is relevant to the context of a patient embarking on medical treatment. This view of autonomy is not a new one and scholars now discuss it under the broad heading of narrative autonomy.

In managing our identity and planning our future we ask two questions: 'what should I do' and 'who should I be?'<sup>77</sup> In the process of answering these questions, we set out our life's story and it is from the continuity of this story that we establish continuity of being.<sup>78</sup> The planning of life's story is about

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<sup>76</sup> Christman, above n.39, 145.

<sup>77</sup> J.Bransen, „Personal Identity Management“ in K.Atkins and C.MacKenzie (ed), *Practical Identity and Narrative Agency* (Routledge, New York, 2008), 113.

<sup>78</sup> Atkins, above n.74, 79.



‘integrat[ing] my past, present and anticipated attributes.’<sup>79</sup> Intimately linked to this process of self-definition and continuity of story is the physical body because, as Atkins notes, ‘our bodies are simultaneously something that we have and something that we are’<sup>80</sup> and are an ‘integral component of our narrative identity.’<sup>81</sup> This then is the key to the relevance of narrative autonomy in the context of pre-treatment advice. We obtain information which helps us to identify our possible future selves and an integral component of the possible futures is our physical health. If we are unaware of the possibilities then we lose the right of authorship: the story is potentially taken out of the hands of the author.

The concept of life as a story with individuals in charge of the narrative is further explained by Bransen who describes it in the following terms: lives ‘do not just happen or take place; they are lived and living a life means at least once in a while, facing practical problems and solving them by determining the best alternatives of oneself.’<sup>82</sup> Thus a key part of living our lives is determining future paths and this is done through the process of identifying possible future selves, or, as Bransen explains it, of facing the difficult choice and wondering who we should or would be if we take a particular path.<sup>83</sup> It is all about a process of ‘imaginative projection’ and ‘helping us envisage future possibilities and to make sense of the alternatives we face.’<sup>84</sup>

The recommended model of autonomy for the purposes of legal consideration of pre-treatment advice is therefore narrative autonomy. It is appropriate to define the patient as the author of their future, the one who is to consider the possible paths lying before them and then choose the most

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<sup>79</sup> Ibid, 91-92.

<sup>80</sup> Ibid, 82.

<sup>81</sup> Ibid, 86.

<sup>82</sup> J.Bransen, above n.77, 108.

<sup>83</sup> Ibid, 107.

<sup>84</sup> C.Mackenzie, „Identity and Self Transformation“ in K.Atkins and C.MacKenzie (ed), *Practical Identity and Narrative Agency* (Routledge, New York, 2008), 122-123.

appropriate one. This model is consistent with both individual and relational conceptions of autonomy and supports the fundamental requirement of liberty or freedom of choice. Narrative autonomy provides a clear view of autonomy which, for present purposes, avoids the complexities of the individual vs. relational debate and embraces the essence of autonomy upheld by all theorists.

### **Some final thoughts**

[10.80] Autonomy is a term employed to justify the doctrine of 'informed consent' yet, as Coggon notes, it is 'rare for a judge to provide an explicit, philosophical investigation of autonomy.'<sup>85</sup> The judiciary refers to autonomy in a manner that implies a common and implicitly agreed upon, understanding of the nature of autonomy and the personal authority that it connotes. But even the most cursory of reviews of the scholarly literature on autonomy will reveal that this is not the case. Autonomy as an ideal is almost universally supported but it is not universally defined.

It is important to recognise, however, that this lack of a universal definition may not, on the whole, be a bad thing. A complex and fundamental aspect of humanity, such as autonomy, is perhaps best dealt with via a broad brush. As Gerald Dworkin has suggested, it may be more appropriate to 'characterise' rather than to 'define' complex philosophical concepts (such as autonomy) if they are to retain any meaning. Any attempt to 'specify necessary and sufficient conditions' may well drain it 'of the very complexity that enable[s] it to perform its theoretical role.'<sup>86</sup> Dworkin also challenges the very existence of a 'core meaning that underlies all these various uses of the term.'<sup>87</sup> But the preceding discussion has demonstrated that there are clear and consistent themes and ideals. Three core considerations are: liberty,

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<sup>85</sup> Coggon, above n.7, 236.

<sup>86</sup> Gerald Dworkin, above n.16, 6

<sup>87</sup> Ibid, 7.

choice and self-definition. Similarly, it is possible to identify, at the heart of the debate, a self-authoring individual. And it is this self-authoring individual who can serve to characterise the term autonomy and enable us to create a more accessible and transparent legal consideration of the provision of pre-treatment advice. As Schneider has suggested:

... some simplifications of life's complexity is necessary if human problems are to be handled practically and promptly, if comprehensible rules are to be devised, if useful precedent is to be developed, if institutions are to function smoothly.<sup>88</sup>

For now, we will put the discussion of autonomy and the characterisation of the self-authoring individual to one side and address the concept of choice. It is in the adoption of the model of narrative autonomy, set alongside the rejection of consent (and adoption of choice) that we will find an appropriate simplification of the complexity of 'informed consent'.

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<sup>88</sup> Schneider, above n.38, xvii.

## Chapter 11: Choice or Consent?

### Defining terms

[11.10] The preceding Chapters have tracked the ongoing judicial struggle with the central themes of the doctrine of ‘informed consent’.<sup>1</sup> Central to this struggle is the unhappy marriage of ‘not just two elements but two doctrines: one a doctrine of informational obligation which, contingently bears on consensual decision-making; the other a defence of consent to an intentional tort’<sup>2</sup>; that is, a ‘marriage’ of negligence and trespass within the same ‘doctrine’. As we have seen, the central argument of this thesis is that the legal test of ‘informed consent’ and its accompanying language do not achieve the foundational aim of protection of patient autonomy. A more effective model requires a rejection of loose language and an adoption of carefully defined terms. This can be achieved by a removal of the concept of consent in favour of choice. Despite consent being described as ‘poorly defined and curiously unstable’<sup>3</sup> it does have a specific legal definition in the law of tort. Its legal purpose is to negative trespass and it is not related to the quality of pre-consent information. Choice, however, does rely on quality of information and is a process that occurs prior to consent. It is therefore essential that a model of choice is formulated and placed within the legal framework around consideration of the provision of advice prior to treatment.

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<sup>1</sup> These themes are of course the provision of advice, protection of autonomy and bodily integrity and the identification of appropriate professional standards.

<sup>2</sup> Beyleveld and Brownsword, *Consent and the Law* (Hart Publishing, Portland Oregon, 2007), 174. This concept was first raised in Chapter 1 and discussed in the specific context of Australia in Chapter 7.

<sup>3</sup> I. Leader-Elliott and N. Naffine, „Wittenstein, Rape Law and the Language Games of Consent“ (2000) 26 *Monash University Law Review* 48, 48.

We have now arrived at the final stage of the critique of ‘informed consent’ and this Chapter will focus on the concept of consent. It will become clear that the interests of both the patient and doctor will be best served when the language of consent is removed from the discussion. We will then turn to the idea of choice, establish a clear account of the process of choosing (which includes provision of appropriate advice) and briefly consider rational choice theory to demonstrate why choice is the more appropriate model in this context. Finally, Sally’s choice process will be considered and the precise nature of her loss, once it is framed in these terms, will be demonstrated. Thus the logic of informed choice as opposed to ‘informed consent’ will be demonstrated.

## Consent

[11.20] The introduction to this thesis, and the elaboration on the law in Parts I and II demonstrated that there have been some clear judicial statements rejecting the language of consent as appropriate when examining the provision of advice prior to medical treatment.<sup>4</sup> However, as also highlighted in these earlier discussions, the interpretation of key decisions and subsequent scholarly discourse has embraced the term ‘consent’ and resulted in the wide acceptance of the label ‘informed consent.’<sup>5</sup> It is important to note at this point that, as with autonomy (discussed in Chapter 10), consent is adopted and adapted in judicial and scholarly discussion but never defined. It is, yet again, an example of an assumed understanding of a concept. A close consideration of the philosophical,

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<sup>4</sup> See for example the clear statement in *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ), here the Court specifically stated that the issue was one of the provision of advice prior to treatment and not one of consent. This authoritative judgment contained the assertion that consent is relevant in the context of actions framed in trespass and not negligence.

<sup>5</sup> This was recognised by Kirby J in *Rosenberg v Percival* (2001) 205 CLR 434, 476-477 where His Honour acknowledged the rejection of notions of consent in the earlier decision of *Rogers v Whitaker* but explained that the concerns dealt with in both *Rogers* and *Rosenberg* were the same as those commonly dealt with in the legal and medical literature under the label of ‘informed consent’.

judicial and plain language meaning of consent reveals that, as suggested by the High Court in *Rogers v Whitaker*,<sup>6</sup> consent has a narrow meaning that is only truly relevant in the context of trespass to the person.<sup>7</sup>

Consent is a social activity. It is a communication by one person to another of the result of the internal processes of choice. It is important to remember that consent *simpliciter* is the end of a process and cannot be reduced to the *minutae* of information provided to the consenter, or the quality of that internal, and often deeply personal, process of choice. Consent is quite simply an agreement. The law does not address the quality of the consent. It is an absolute term and is either positive or negative. Significantly, consent, unlike autonomy or choice, lacks a deeper philosophical meaning and is a straightforward word, with a simple and straightforward meaning, that has become overly complicated through the evolution of the doctrine of 'informed consent.'

To effectively challenge the relevance of the notion of consent it is appropriate to clearly define it. This is best achieved through a brief consideration of the plain English, legal, and philosophical dictionaries. If we turn first to the plain English dictionary, the definition of consent is straightforward. It is defined as an expression of willingness, a granting of permission, an agreement.<sup>8</sup> Consent is not a deeply philosophical or conceptually difficult term. Indeed it is absent from any of the philosophical dictionaries consulted when I was attempting to come to terms with the

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<sup>6</sup> *Rogers v Whitaker* (1992) 175 CLR 479.

<sup>7</sup> It is worth noting here that consent, like autonomy, has a rich body of literature which is concerned with seeking a coherent definition in the context of criminal offences against the person. This is, however, well outside of the scope of this thesis but an illuminating discussion of consent in the context of criminal offences can be found in: I. Leader-Elliott and N.Naffine, „Wittenstein, Rape Law and the Language Games of Consent“ (2000) 26 *Monash University Law Review* 48.

<sup>8</sup> *The Oxford Encyclopedic Dictionary*, (Clarendon Press, Oxford, 1991).

language surrounding pre-treatment advice.<sup>9</sup> Similarly, those few Legal Dictionaries which define consent, simply mirror the plain English definition. It is described as 'affirmative acceptance. Actual agreement by a plaintiff to the action complained of,'<sup>10</sup> and 'an agreement to expose oneself to a risk or participate in an activity. Consent generally operates as a complete defence at common law for trespass to the person.'<sup>11</sup> It is notable that in other, equally-common legal dictionaries, the term consent is not defined,<sup>12</sup> thus indicating the assumption that consent is to be given its plain English definition: an affirmation or agreement. There is no reference to the quality of the information or the process of making the decision to consent in any of the definitions, yet both play a significant role in the doctrine of 'informed consent.'

How then can such a simple term have travelled so far from its plain English, and apparent legal meaning to encompass broader issues including the quality of advice given prior to treatment. A clue can be found in the *New Oxford Companion to Law*<sup>13</sup> which supplies a contextual definition with the inclusion of a definition of 'consent to treatment.' This definition notes that the expectation of patient consent to treatment is a 'legal expression of self-determination' and reflects the primacy of autonomy. The discussion at this point focuses on the right to refuse life-preserving treatment which prevails over the ethical principle of sanctity of life. It is significant that the provision of advice prior to treatment is not initially discussed. Instead, the definition refers to the proposition that treatment in the absence of consent will give rise

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<sup>9</sup> These included the *Fontana Dictionary of Modern Thought* (Fontana, Collins, 1977), *Penguin Dictionary of Philosophy*, (2<sup>nd</sup> ed, Penguin, London, 2005), and *The Oxford Companion to Philosophy*, (Oxford University Press, Oxford, 1995).

<sup>10</sup> *Butterworths Concise Legal Dictionary*, (3<sup>rd</sup> ed, LexisNexis, Sydney, 2004).

<sup>11</sup> *Oxford Australian Law Dictionary*, General Ed Trischa Mann, (Oxford University Press, Melbourne, 2010).

<sup>12</sup> See for example, *CCH Macquarie Dictionary of Law, Words and Phrases Legally Defined*, (4<sup>th</sup> ed, LexisNexis Butterworths, Sydney 2000) and *Words and Phrases Judicially Defined in Canadian Courts and Tribunals*, (Toronto, Carswell, 1993).

<sup>13</sup> P. Cane and J. Conaghan ed, (Oxford University Press, Oxford, 2008).

to the tort of battery. Once the narrow definition of consent to treatment is explained, the definition then expands to include consideration of the appropriate level of information. Interestingly there is an assertion that 'Courts have declined to give full effect to the ethical doctrine of informed consent.'<sup>14</sup> This is to be contrasted with a statement in the next paragraph that failure to inform the patient about the risks, side effects and alternatives will not give rise to an action in battery but in negligence through the doctrine of informed consent. This somewhat muddled definition reflects the problematic state of the existing use of language. The *New Oxford Companion to Law* purports to simplify and explain the law yet cannot avoid the inconsistencies of a law which is not about consent but relies upon the language of consent. It is this internal inconsistency of the existing doctrine of 'informed consent' that lays the foundations for later conceptual difficulties and, as explained above,<sup>15</sup> the linking of a wrong with a logically irrelevant harm (that is, the dignitary wrong of withholding of information being linked to, and measured by, the infliction of an unrelated physical harm).

A final source of interpretation of a legal term is, of course, judicial discussion. Superior Courts in both Australia and the United Kingdom have specifically rejected the role of 'consent' in the evaluation of the quality of pre-treatment information. Lord Donaldson in *Sidaway v Board of Governors of the Bethlehem Royal Hospital*<sup>16</sup> clearly stated that he was 'wholly satisfied that as a matter of English law a consent is not vitiated by a failure on the part of the doctor to give the patient sufficient information before the consent is

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<sup>14</sup> Ibid.

<sup>15</sup> This issue was first raised in Part I when we explored the appropriate standard of care but was specifically highlighted in Part II when the efficacy of the current causative test was challenged.

<sup>16</sup> [1984] QB 493.



given.<sup>17</sup> Similarly, in *Rogers v Whitaker*<sup>18</sup> the High Court stipulated that ‘consent is relevant to cases involving trespass not negligence ... the question is not one of consent ... Battery is negated by the patient being advised in broad terms of the nature of the procedure to be performed.’<sup>19</sup> On this view then, the quality of pre-treatment advice is not concerned with consent.

At law, consent is defined in plain English terms. It is the active agreement to a particular course of treatment and does not rely on a particular quality of information. The use of the term ‘informed consent’ is inconsistent with clear judicial comments that the term should not be used. This inconsistency leads those attempting to clarify the law<sup>20</sup> to make incoherent statements to the effect that there is no doctrine of informed consent but then to presuppose its existence and declare that the doctrine of informed consent rests on the provision of advice prior to treatment. It is essential therefore that we turn away from the problematic language of consent and adopt a language which reflects the process that actually occurred before consent was given and will enable an appropriate identification and measurement of loss. The appropriate term is ‘choice’.

## Choice

[11.30] Turning now to choice, a consideration of the nature of choice will clarify why choice, not consent, more accurately reflects the interplay of rights and duties in the pre-treatment conversation. The important point with respect to choice is that it is repeatedly referred to as an internal process. A further relevant consideration in the context of this thesis is that not only is

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<sup>17</sup> *Ibid*, 511.

<sup>18</sup> (1992)175 CLR 479.

<sup>19</sup> *Ibid*, 490.

<sup>20</sup> For example, the authors of *New Oxford Companion to Law*, above n.13.

choice both internal and a process (as opposed to an end point), but it is a deeply personal process that cannot be measured by physical outcomes. A consistent theme of the definitions is the evolutionary nature of an individual's choice and the significance of options. Choice evolves and matures as the individual becomes aware of all relevant options and weighs them against each other. Thus the process of making a choice is an integral part of the pre-treatment conversation.

As with consent, if a clear understanding of the nature of choice is to be gained, we must first begin with a basic definition of the term. Turning first to the plain English definitions: In *The Oxford Encyclopedic Dictionary*, choice is defined as 'The act or instance of choosing, a range from which to choose. To choose is to select out of a greater number.'<sup>21</sup> *The New Shorter Oxford English Dictionary* refines the definition and refers to choice as 'deciding between possibilities. A scope or field of possibilities.'<sup>22</sup> The significance of different options or possibilities is also emphasised in the only philosophical dictionary consulted that included choice,<sup>23</sup> where choosing and deciding were linked together and defined as '... mental events or processes that may issue in ordinary actions. Selecting from a range of options. A mental event.' The third and final source of definition is of course legal dictionaries and judicial discussion. The term choice is not included in general legal definitions but *Words and Phrases Legally Defined*<sup>24</sup> refers us to a High Court decision which defined choice as 'meaning no more than to make a selection

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<sup>21</sup> *The Oxford Encyclopedic Dictionary, Oxford* (Clarendon Press, Oxford, 1991).

<sup>22</sup> *The New Shorter Oxford English Dictionary Volume 1*. (Clarendon Press, Oxford 1993).

<sup>23</sup> *The Oxford Companion to Philosophy*, ed. Ted J Honerich, (Oxford University Press, Oxford, 1995). Choice was not included in: *The Cambridge Dictionary of Philosophy*, (Cambridge University Press, Cambridge 1996), *Fowlers Modern English Usage*, (3<sup>rd</sup> ed, Clarendon Press, Oxford 1996), or *Penguin Dictionary of Philosophy*, (2<sup>nd</sup> ed, Penguin Melbourne, 2005).

<sup>24</sup> *Words and Phrases Legally Defined*, (4th ed, LexisNexis Butterworths, Sydney 2007).

between different things to alternatives submitted, to take by preference out of all that are available.’<sup>25</sup>

It is clear, therefore, that choice can be distinguished from consent. Choice is the process that occurs prior to the granting of consent and, significantly in this context, relies upon a clear and complete array of options. Thus when considering the provision of information, the significance of choice is easily identified: the absence of information reduces the range of options and undermines the careful balancing process that is choice.

### **A model of choice**

[11.40] The provision of advice and information is integral to the process of choice. The concept of choice is not enclosed in a static definition and there is a vast body of scholarly work exploring choice theory in psychology, education and economics.<sup>26</sup> It is well beyond the scope of this thesis to explore this body of work in any depth but it is worth pausing and taking a brief look at the essentials of one of the more common theories of choice: rational choice theory. The key to all versions of choice is the ability to consider the future (or, more specifically, to consider possible futures) and then choose the best or most appropriate path to the preferred possible future. In denying access to realistic insight into possible futures, there is an undermining of the choice process and this is where the loss is sustained. It is not related at all to the granting of consent, the agreement to the touching of

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<sup>25</sup> *Judd v McKeon* (1926) 38 CLR 380, 383 (Knox CJ, Garan, Duffy and Starke JJ).

<sup>26</sup> See for example, M. Dan-Cohen, „Conceptions of Choice and Conceptions of Autonomy“ in *Harmful Thoughts. Essays on Law, Self and Morality*,“ (Princeton University Press, Princeton, 2002), R. Hastie and R. M. Dawes, *Rational Choice in an Uncertain World: The psychology of judgment and decision making* ( Sage Publications, London, 2001), D. Gauthier, *Morals by Agreement* ( Oxford University Press, ,Oxford 1986), M. Allingham *Choice Theory: a Very Short Introduction* (Oxford University Press, Oxford, 2002) and J. Riley *Liberal Utilitarianism: Social Choice Theory and J.S. Mills Philosophy* (Cambridge, Cambridge University Press, 1988).

one's body. Consent is the endpoint of the choice process and the loss has occurred before that point is reached.

The process of choice and the essential nature of information regarding possible futures is clearly enunciated in rational choice theory. Rational choice involves a choice set and depends upon preference. The process at the heart of rational choice theory is selection and it has been suggested that 'choice is about control, about achieving what each individual wants. To be able to shape one's life.'<sup>27</sup> Thus in being able to control the future and make an informed selection, the 'chooser' must be aware of all of the elements of the choice set; they must, in the words of the High Court, be informed of all 'material' information.<sup>28</sup>

The process of making a choice is complex. Rational choice theory identifies four criteria to be met if a choice is to be described as 'rational' (or of value):

1. It is based on the decision-maker's current assets. Assets include not only money but physiological state, psychological capacities, social relationships and feelings,
2. It is based on the possible consequences of the choice,
3. When these consequences are uncertain, their likelihood is evaluated according to the basic rules of probability theory, and
4. It is a choice that is adaptive within the constraints of those probabilities and the values or satisfactions associated with each of the possible consequences of the choice.<sup>29</sup>

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<sup>27</sup> M. Dan-Cohen, „Conceptions of Choice and Conceptions of Autonomy“ in *Harmful Thoughts. Essays on Law, Self and Morality* (Princeton University Press, Princeton, 2002), 126. This author in fact then moves on from a model of choice and expounds a theory of „willing“ a detailed and technical discussion that is well beyond the parameters of this thesis.

<sup>28</sup> *Rogers v Whitaker* (1992) 175 CLR 479.

<sup>29</sup> R. Hastie and R. M. Dawes, *Rational Choice in an Uncertain World: The psychology of judgment and decision making* (Sage Publications, London 2001), 18.

If we examine each of these criteria in the context of advice prior to treatment it becomes apparent that they can be linked easily with the process of diagnosis, identification of options and discussion of those options.<sup>30</sup> Clearly the patient's 'assets' include their relationships with their family, their age and, most importantly, the nature of their condition. The second criterion is the 'missing link' in the pre-treatment advice situations. When the doctor fails to explore all possible options with the patient, the patient is unaware of all the consequences of their choice. If there is no discussion of 'material' risks, then there is an obvious gap in the choice process. Similarly, if the information is not conveyed to the patient, then they are unable to meet the third criterion. There is no realistic evaluation of the likelihood of a particular outcome (in the patient's optimistic view, this is perhaps a return to good health) in the absence of complete information. If a particular likelihood is not even mentioned, then there is no ability to assess the probability of a preferred outcome. Finally, the fourth criterion is also undermined in the absence of complete information. The patient cannot adapt their choice within the constraints of probabilities and possibilities when information is either withheld or overlooked. They are unable to evaluate values or satisfactions associated with consequences of which they are unaware. Rational choice theory turns on successful and comprehensive communication of options and incomplete communication undermines the rationality of choice. A significant component of rational choice theory is the ability to assess thoroughly future possibilities and consequences.<sup>31</sup> It is essential that we are able to predict what will make us happy after we choose a particular path.<sup>32</sup> This predictive process is broader than mere expectations of happiness and includes a balancing of options, an evaluation of all aspects

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<sup>30</sup> For the purposes of this discussion, the term „patient“ will be used in place of „decision-maker“.

<sup>31</sup> Hastie and Dawes, above n.29, 44.

<sup>32</sup> Ibid, 199

of the expected consequences and a clear understanding of what we want and how best to achieve it.<sup>33</sup>

The theory of rational choice then can be seen as 'primarily concerned with preferences between states of affairs conceived as alternative possibilities realisable in action.'<sup>34</sup> When a patient is not fully informed, the alternative possibilities are not all available for their assessment and it is quite easy to identify a loss. The patient is not empowered to be a 'rational' chooser and it is the choice that precedes the consent that is flawed, not the consent itself.

Drawing this discussion back to the central theme of the provision of advice prior to treatment, it becomes clear that choice, and the process of choosing, is at the heart of both judicial and scholarly discussions. Some scholars prefer the language of 'choice' to that of consent: Jones has argued that 'it is a misnomer to talk of informed consent since a patient's right to the information will enable him to make a meaningful choice,'<sup>35</sup> and Faden and Beauchamp referred us to the *Canterbury* decision and the 'informed exercise of choice.'<sup>36</sup> Similarly Berg et al described the 'underlying rationale' of the doctrine of 'informed consent' as the empowerment of patients to 'exercise choice'<sup>37</sup> and Ronald Dworkin, in describing autonomy, referred to the 'integrity of the choosing agent' and the ideal of 'self-creation.'<sup>38</sup> Similarly, the judiciary has appealed to choice. As we have seen, it was central to the discussions of the High Court in *Rogers v Whitaker*.<sup>39</sup> This language has been

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<sup>33</sup> Ibid, 199-200 and 252.

<sup>34</sup> D. Gauthier, *Morals by Agreement* (Oxford University Press, Oxford, 1986), 22.

<sup>35</sup> M.A. Jones, *Medical Negligence* (Lawbook Co, Sydney, 2003), [6-105].

<sup>36</sup> R.R. Faden and T.L. Beauchamp, *A History and Theory of Informed Consent* (Oxford University Press, New York, 1986), 133. They were referring to *Canterbury v Spence* 464 Fed Report 2d, 772 (1972).

<sup>37</sup> J.W. Berg, P.S. Appelbaum, C.W. Lidz, L.S. Parker, *Informed Consent: Legal Theory and Clinical Practice* 2<sup>nd</sup> ed, (Oxford University Press, New York, 2001), 48.

<sup>38</sup> Ronald Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia and Individual Freedom* (Vintage Books, New York, 1993), 224. This linking of choice and „self-creation“ is consistent with my discussion here about choice and self-authorship (narrative autonomy discussed in Chapter 11).

<sup>39</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

adopted in later decisions. In *Rosenberg v Percival*, for example, Kirby J supported his argument with the assertion that it is 'more respectful of the entitlement of patients, whose privilege of choice this area of the law is intended to reinforce,'<sup>40</sup> and Basten JA, in the New South Wales Court of Appeal, suggested that the '...duty to warn might more aptly be described as a duty to inform or communicate information, so as to permit the patient to make an informed choice,'<sup>41</sup> and in the same Court, Santow AJA referred to the notion of 'informed choice.'<sup>42</sup>

Thus choice is already an accepted part of the language surrounding the provision of pre-treatment advice. But it is not carried through to its conclusion, and the practical reality is that, despite the adoption of the language of choice, Courts and scholarly debates tend to shift focus back to the notion of consent. The enquiry needs to maintain the focus on choice as it is here that the true loss is to be found. The consent to treatment comes after a flawed choice-making process as the patient has been denied the right to complete information and is no longer in charge of their personal narrative. It is the denial of choice, through inadequate information, that is the true loss and it is this that should be recognised. Once the discussion becomes centred on informed choice, as opposed to informed consent, the nature of the loss becomes evident and the essential causative link more readily identified. If we return to Sally and her choice process, this argument becomes clearer.

### **Sally's Choice**

**[11.50]** As we have seen, Sally has a degenerative condition that, if left alone, will result in blindness within 5 years. She sought advice from her doctor

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<sup>40</sup> *Rosenberg v Percival* (2001) 205 CLR 434, [154], (Kirby J).

<sup>41</sup> *Ellbourne v Gibbs* [2006] NSWCA 127, [57] (Basten JA).

<sup>42</sup> *Johnson v Biggs* [2000] NSWCA 338, [53] (Santow AJA).

and two key pieces of information were withheld from her: first that she has no possibility of recovery (the most favourable outcome is a slowing down of the degeneration of her sight), and second, that there is a small (1 in 14,000) chance that the procedure could result in immediate onset of blindness. The omission of these two possibilities from Sally's choice set means that her process of evaluation is flawed. She is unaware of the reality of her situation. Her choice process can be diagrammatically represented in a 'decision-tree', a diagram which, as explained by Hastie and Dawes, reminds us 'that the crucial first step in understanding any decision is to describe the situation in which the decision occurs.'<sup>43</sup> Figure 1 represents Sally's view of her choice. Figure 2 represents the reality of her process. The lighter coloured box in Figure 1 represents fictions that Sally believes in, and in Figure 2, crucial elements of her choice set of which Sally is unaware. The lighter boxes therefore represent the flaws in her choice process.

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<sup>43</sup> Hastie and Dawes, above n.29, 33.



FIGURE 1: SALLY'S VIEW

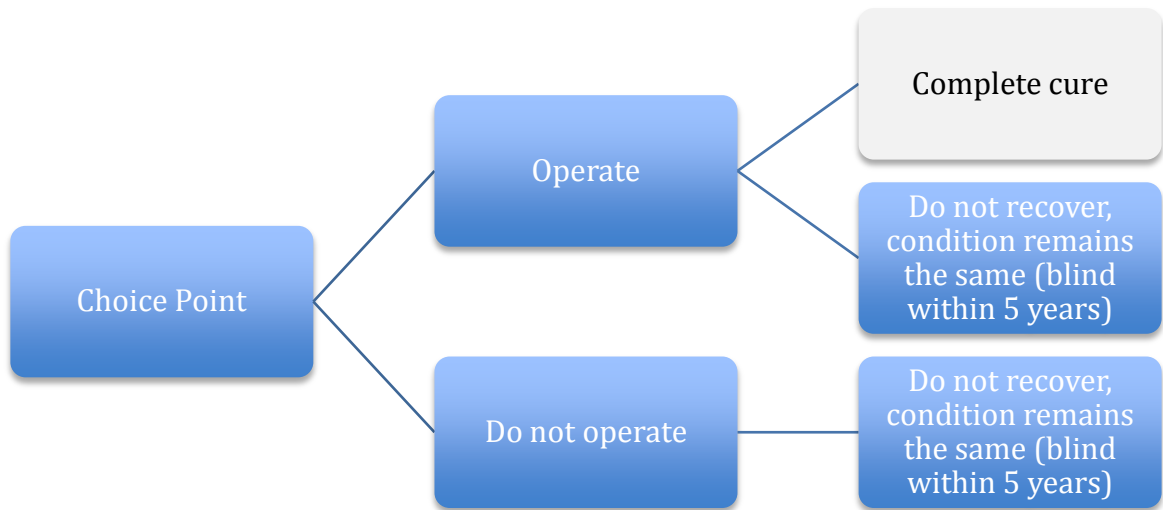
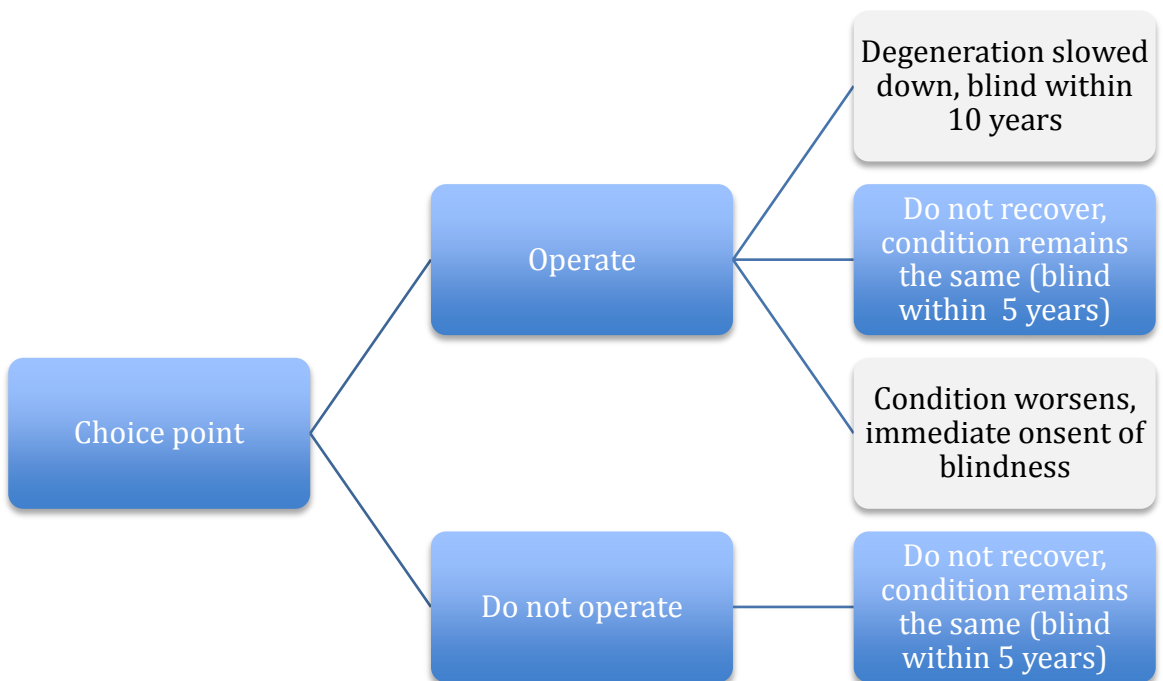


FIGURE 2: REALITY



We see here that Sally's view of reality is very straightforward. Proceeding with the treatment has no possible negative outcome. She either recovers or remains the same. The reality of her situation, however, is significantly different. She can, at best, slow down the degeneration and, at worst, accelerate it to the point that she is immediately blind. Sally has no insight into this aspect of reality; she is not addressing 'realisable' possibilities;<sup>44</sup> the future she envisages is a fiction for there is no possibility of a complete cure. Sally has clearly suffered a loss. She is unable to realistically assess her options and her possible future selves. Despite this the current framework which focuses on the end point of the choice process - the consent (or not) to treatment - fails to recognise the very real loss that Sally has sustained. Her consent is valid, as she has agreed to the surgery and given permission to the touching, but the choice behind that consent is flawed and rendered 'meaningless.'<sup>45</sup>

We cannot consent to a particular path until we have made a choice between possible paths. Consent is a social and legal communication with both social and legal consequences. Choice on the other hand is a private and internal activity. It represents the exercise of the autonomous right to choose a particular path. The consent is then the communication of that choice and if the choice is meaningless then there is not true consent. Importantly, however, even if the consent is based on a flawed choice it will still constitute sufficient legal consent to negate an action in trespass to the person.

The loss then is a process loss. Autonomy and the authority to make choice based upon clear and realisable options are both denied. The existing approach to 'informed consent' is therefore flawed. The judiciary seeks to

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<sup>44</sup> Gauthier, above n.34, 22.

<sup>45</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

protect patient autonomy and begins with the basic right to sufficient information to infuse choice with meaning.<sup>46</sup> The adoption of the trespassory notion of consent then serves to misdirect the enquiry and we have seen the ongoing struggle to link two conceptually different ideals: the right to bodily integrity and the right to information and meaningful personal choice.

We have three useful legal concepts at play here: 'Consent' (appropriately dealt with in the context of trespass to the person, but misplaced in the negligence enquiry), autonomy (currently lacking a sufficiently precise definition) and choice (introduced in the discussions but not afforded any legal significance). The way forward is to return consent to the confines of trespass and move to the process of choice. If this is done, then the patient will be empowered to make their own choice and maintain control of their personal narrative. Such a shift does not require a significant overhaul of the law. Rather it represents the establishment of a realistic and attainable legal 'doctrine' which would sit comfortably within the existing framework of negligence law and formally apply the existing judicial language of consent.

Before drawing this discussion to a close I acknowledge that the quantification of damages for such a dignitary harm may be problematic. Nonetheless, I argue that this is not a problem that has defeated the law in the past. One needs only consider the chequered history of 'nervous shock' (now mental harm) or the willingness of the courts to award damages for loss of expectation of life or pain and suffering to see that intangible losses can be, and have been, quantified. Significantly, in *Tame and Annetts*<sup>47</sup> the High Court asserted that psychiatric harm 'is not damage of a different kind from

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<sup>46</sup> Ibid.

<sup>47</sup> *Tame v State of New South Wales; Annetts v Australian Stations Pty Ltd* (2002) 211 CLR 317.

physical injury'<sup>48</sup> and were able to apply general damages principles to the specific issue before the court.

Whilst the actual quantification of damages for the harm suffered when choice is denied is well outside of the scope of this thesis, it is appropriate to consider briefly what approach to such quantification could be adopted by the Courts. This brief discussion will outline one general approach which could be utilised. While the discussion will not be comprehensive, my aim is to indicate that whilst it may be difficult to quantify the damages for a dignitary harm, it is neither impossible nor inconsistent with established law to do so.

The starting point is that damages for all non-economic losses are notoriously difficult to calculate with any mathematical certainty. This does not, however, represent an insurmountable obstacle to the award of damages for such loss. In the existing negligence framework, damages are routinely awarded for intangible losses such as pain and suffering, loss of amenities and loss of expectation of life, all of which are analogous to the dignitary harm suffered when a patient is denied the right to make an informed choice. The problematic nature of these forms of loss has been acknowledged by the judiciary and the legislature. However, in the High Court decision of *Todorovic v Waller*,<sup>49</sup> Gibbs CJ and Wilson J reminded us that whilst it is difficult to assess damages in the absence of physical or economic loss, as the quantum of the harm is 'less obvious,' it does not mean that it is 'less real.'<sup>50</sup> It is my argument that dignitary harm is analogous to the types of non-economic loss which are already recognised by tort law. Therefore, I argue dignitary harm is as real as any physical or economic one but more difficult

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<sup>48</sup> Ibid, 368, McHugh J.

<sup>49</sup> (1981) 150 CLR 402.

<sup>50</sup> Ibid, 412 (Gibbs CJ and Wilson J).

to quantify. It has been recognised in existing tort law, that mere difficulty in quantification should not prevent the courts engaging with such loss and as stated in *Todorovic* ‘the difficulty inherent in the assessment of damages provides no reason for the courts to shirk the task of arriving at the estimate most likely to provide fair and reasonable compensation. But it may provide reason for approaching it with some caution.’<sup>51</sup>

The type of dignitary harm I am considering in this context is distinct from the physical injury which has traditionally been linked to ‘informed consent’ and which is inflicted prior to the provision of medical treatment. It is an abstract harm, that is analogous to the mental anguish and insult that occurs as a result of discriminatory behaviour. The essential harm is always dignitary as it involves the loss of the right to choose with appropriate knowledge. Whilst the harm can exist alongside a physical injury, it is a separate form of harm and must be treated as such. In seeking an appropriately cautious model of damages, therefore, a relevant comparator is to be found in anti-discrimination law, which deals with issues of human dignity. Human dignity (and therefore dignitary harm), is a potentially imprecise notion and yet it is one which is of ‘value and worth to all individuals in society.’<sup>52</sup> It is helpful therefore to consider how Australian courts have placed a value on the harm suffered to dignity when discrimination has occurred. The preferred approach of the Federal Court of Australia has been to turn to tort law for guidance on the determination of damages. It was suggested by Lockhart J in *Hall v Sheiban*<sup>53</sup> that it ‘would be unwise to prescribe an inflexible measure of damage in cases of this kind’<sup>54</sup>

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<sup>51</sup> *Ibid*, 413 (Gibbs CJ and Wilson J).

<sup>52</sup> C. Foster, *Human Dignity in Bioethics and Law* (Hart Publishing, Oxford, 2011), 122. Here Foster was quoting from a decision of the Constitutional Court of South Africa, *National Coalition for Gay and Lesbian Equality v Minister of Justice* (1998) 6 BHRC 127, [30] (Ackermann J). This is relevant in this context as it is dealing with the two concepts under consideration which are anti-discrimination law and human dignity.

<sup>53</sup> *Hall v Sheiban* (1989) 20 FCR 217, a decision dealing with the harm suffered as a result of sexual harassment.

<sup>54</sup> *Ibid*, [239] (Lockhart J).

but his Honour went on to say that ‘the measure of damages is the same as the general principles respecting measure of damages in tort, it is the closest analogy that I can find and one that would in most foreseeable cases be a sensible and sound test.’<sup>55</sup> This can, in turn, provide guidance to courts assessing damages for the denial of choice.

It is clear then that damages could be assessed for dignitary harms, utilising existing tort principles. What would this mean in practice? In much the same manner as in other negligence situations, it would require consideration of the facts and circumstances before the court: by looking at the plaintiff and determining what personal loss was suffered by the identified wrong. Some guidance is provided by a decision from the English Court of Appeal where Mummery LJ acknowledged the difficulty of assessing intangible losses but was nevertheless able to suggest a way forward noting that ‘the courts and tribunals have to do the best they can on the available material to make sensible assessment.’<sup>56</sup>

A similar point was made by May LJ in *Alexander v Home Office*<sup>57</sup> ( a decision cited with approval by the Australian Federal Court in *Hall v Sheiban*<sup>58</sup>) when he concluded that with respect to the assessment of damages, ‘it is impossible to say [with certainty] what is restitution [in these cases], the answer must depend on the experience and good sense of the judge and his assessors.’<sup>59</sup> Thus, consistent with all other areas of negligence law, the assessment of damages in the context of the dignitary harm identified here is not a science. Rather it will require a careful and considered balancing of factors and will be left to the discretion of the courts. If there is concern at a later date that

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<sup>55</sup> Ibid.

<sup>56</sup> *Vento v Chief Constable of West Yorkshire Police* [2002] EWCA Civ 1871, [51] (Mummery LJ).

<sup>57</sup> [1988] 2 All ER 118.

<sup>58</sup> (1989) 20 FCR 217.

<sup>59</sup> *Alexander v Home Office* [1988] 2 All ER 118, 122 (May LJ).

damages are inflated (or perhaps marginalised) then, as with non-economic loss suffered as a result of negligent infliction of physical harm, the legislature may deem it prudent to step in and impose legislative controls.<sup>60</sup> In short, damages for the dignitary harm suffered when insufficient treatment information is provided and choice is denied will reflect a straightforward adaption and application of well-established negligence principles.

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<sup>60</sup> Refer *Civil Law (Wrongs) Act 2002* (ACT) s99, *Civil Liability Act 2002* (NSW), Division 3, *Personal Injuries (Liabilities and Claims) Act 2003* (NT) s24, *Civil Liability Act 1936* (SA) s52, *Civil Liability Act 2002* (Tas) s27, *Wrongs Act 1958* (Vic), s28G, *Civil Liability Act 2003* (WA) ss9 and 10 which all provide guidance to and impose caps on, the calculation of damages for non-economic loss.

## Chapter 12: Informed Choice

### Rejecting informed consent

[12.10] We all have the right to choose the path of our medical treatment. In choosing what path to take, we must be provided with sufficient information to make an informed (or ‘rational’,<sup>1</sup> or ‘meaningful’<sup>2</sup>) decision. This truism is easy to accept but, as we have seen, it does not translate comfortably into law. The doctrine of ‘informed consent’ is the accepted legal mechanism for protecting this right. It is, however, a faulty mechanism that represents the unhappy and unsuccessful marriage of two doctrines.<sup>3</sup> This thesis has explored the problematic nature of this ‘marriage’ and now draws the logical conclusion that a separation of the doctrines is in order.

Negligence ‘is a basis of liability [concerned with] conduct that falls below the standard regarded as normal or desirable.’<sup>4</sup> The implementation of the current doctrine of ‘informed consent’ begins with an appropriate exploration of what is the ‘desirable’ amount of information to be provided to the patient. The provision of information is aimed at empowering the patient as a decision-maker and providing them with sufficient information to choose their preferred treatment path. This initial stage of the enquiry thus seeks to protect the autonomous patient and, as we have seen in the preceding Chapters, autonomy is often cited as the foundation of ‘informed consent’.

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<sup>1</sup> *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1984] QB 493, 512 (Lord Donaldson).

<sup>2</sup> In *Rogers v Whitaker* the High Court described a decision based upon insufficient information as „meaningless“ thus it can be implied that a decision made after the provision of sufficient information can be described as „meaningful“, see *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

<sup>3</sup> D. Beylveled and R. Brownsword, *Consent and the Law* (Hart Publishing, Portland Oregon, 2007), 174. This concept was first raised in Chapter 1 and discussed in the specific context of Australia in Chapter 7.

<sup>4</sup> C. Sappideen, and P. Vines (ed), *Fleming’s The Law of Torts* 10<sup>th</sup> ed (Thomson Reuters, Sydney, 2011) 121.



The doctrine stumbles, however, with the importation of the concept of consent, a central feature of the intentional tort of trespass to the person. Indeed, the ‘germinal case’ of *Schloendorff*,<sup>5</sup> from which the doctrine of informed consent is said to have emerged,<sup>6</sup> is in fact a case dealing with trespass to the person and not negligence. As we saw in Part II, it is at the causation stage of the enquiry that the Courts struggle to link the individual right to information to a subsequent, unrelated physical harm. Autonomy is interpreted here as being expressed through the consent to treatment. But autonomy is broader than this and cannot be limited to considerations of bodily integrity. Whilst autonomy and bodily integrity are twin concepts that sit side by side (and in reality the absence of one often undermines the other), they are not one and the same. An exercise of autonomy cannot be purely measured by the invocation of the right to bodily integrity. An individual can maintain their bodily integrity by consenting to a procedure and indicating their willingness to be touched but in the absence of complete information they are not truly exercising autonomy. Their right to form their identity, the essence of self, is undermined.

### *Considering autonomy*

[12.20] The character of autonomy and the basic aims of the law’s approach to pre-treatment discussions must be clearly understood if any meaningful legal intervention is to occur. If we begin, as many judicial discussions of informed consent begin, with Cardozo’s renowned statement,<sup>7</sup> we see that there are some clearly defined characteristics. The autonomous being must be of adult years and ‘sound mind’. They are able to make decisions regarding their

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<sup>5</sup> *Retkwa v Orentreich* 154 Misc. 2d 164 (1992, SC of NY County, NY), referring to *Schloendorff v The Society of the New York Hospital* 211 N.Y 125 (1914).

<sup>6</sup> The language of *Schloendorff* was adopted by Lord Steyn in *Chester v Afshar* [2005] 1 AC 134, [14] and, closer to home, Kirby J described the *Schloendorff* rationale as „fundamental to the formulation adopted by this Court in *Rogers v Whitaker*’ *Rosenberg v Percival* (2001) 205 CLR 434, [142] (Kirby J, referring to *Rogers v Whitaker* (1992) 175 CLR 479).

<sup>7</sup> „Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent, commits an assault, for which he is liable in damages,“ *Schloendorff v The Society of the New York Hospital* 211 N.Y 125 (1914), 129-130.

body and are sovereign in this respect. Importantly, autonomy is expressed by decisions which relate to the physical person, that is, by decisions regarding what is or is not done to one's own body. Here we see the legal principle of physical integrity driving the enquiry. Thus it can be concluded that autonomy is related to physicality in this context and for autonomy to be harmed, physical harm must be sustained. This assertion, made on the basis of a decision involving trespass to the person, has become central to the doctrine of 'informed consent.' Thus a principle of trespass to the person has become central to the practical application of negligence principles to consent to treatment. As the doctrine currently stands, for an identified breach to be seen to have caused a harm, there must be clear evidence of the suffering of a physical harm. Importantly, that harm must be the one about which the doctor failed to inform the patient and, the patient/plaintiff must be able to demonstrate that they would not have proceeded with the treatment had they been informed of the possibility of this harm.

Once again, simple statements obscure the underlying complexities. As outlined in Part II and demonstrated by decisions such as *Rosenberg v Percival*<sup>8</sup> this mandatory linking of the failure to inform with the physical manifestation of the risk often means that the plaintiff/patient will fail in their action. In anchoring the expression of autonomy to the physical, the law overlooks significant aspects of the autonomous individual and their expression of being. Autonomy is not purely corporeal. As we saw in Chapter 10, it is about the person's sense of self which embodies both physical and internal, psychological aspects of being. It is these, less tangible aspect of being that are harmed when insufficient information is provided.

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<sup>8</sup> *Rosenberg v Percival* (2001) 205 CLR 434, refer to discussion in Chapter 7, in particular the discussion under the heading The subjective approach in the High Court: *Rosenberg v Percival* (at [7.50]ff).

To confine autonomy within physical integrity is to deny the essence of the individuality of each individual. Autonomy extends beyond a mere interest in our body. It is a broad concept that encapsulates each person in their entirety. As individuals, we craft our own path through life and it is in that crafting that we express the essence of ourselves as human beings. If we are denied insight into potential treatment paths, including obstacles to health that may exist on those paths, then our sense and expression of self as an autonomous being is diminished. If the law surrounding the pre-treatment conversation is truly to protect the autonomous individual then a definition that looks beyond mere physical interests of each individual must be adopted by the Courts. Such a definition was provided in Chapter 10 when I proposed that we define the autonomous patient as an individual storyteller, reviewing and choosing between possible future selves.

### *Gaps in the Current Approach*

[12.30] This thesis has asserted that we need to move away from the doctrine of 'informed consent' towards a new doctrine of 'informed choice.' In the process of developing this argument some significant gaps in the current approach have been identified and addressed. We have seen that autonomy is a complex concept which is difficult to define. Possibly in response to this complexity the judiciary has avoided any attempt at definition, opting instead to rely on broad statements regarding the rights that are accorded the autonomous individual.<sup>9</sup> It is from this avoidance that one of the most significant gaps in the current approach emerges. The legal enquiry consistently begins with the individual and an affirmation that the autonomous individual sits at the centre of the discussion. This starting point generally takes the form of an affirmation that our bodies are inviolate and

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<sup>9</sup> These are premised on Cardozo J's statement in *Schloendorff* (see above n.7) and were explored in detail Chapter 9, Causation and policy (at [9.10]) and The policy diversion (at [9.20]ff) and then again in Chapter 10.

that we have control over what is (or is not) done to our bodies.<sup>10</sup> Then almost immediately the focus shifts and there is a retreat from the interests of the patient/plaintiff and the substance of the discussion focusses on the actions of the relevant doctor. The question moves from a consideration of the rights of the patient to the duties of the doctor which may not directly correlate with those patient rights, and we see a question of one individual's personal dignity and autonomy being solved by close analysis of the professional standards of another individual (which may not have a direct bearing on the rights of the first individual). In short, the entire enquiry is backwards and the question of patient autonomy is quietly put to one side.<sup>11</sup>

This problem was clearly outlined in Parts I and II and warrant a brief reiteration here. In the United States of America the foundational principle is consistently described as the right of each individual to determine what is (or is not) done to their own body. As stated by Justice Robinson in *Canterbury v Spence*, 'it is the clear prerogative of the patient ... to determine the direction in which their interests lie.'<sup>12</sup> His Honour went on to adopt the language of *Schloendorff* and to talk of the 'informed exercise of choice.'<sup>13</sup> Thus the enquiry emphatically begins with the individual, with a focus on the patient's right to determine the path of their medical treatment. This focus, however, is short-lived and, as outlined in Part I, the judicial eyes are almost immediately lifted from the patient and turned to the treating doctor. As noted in Chapter 2, *Canterbury v Spence* is held out as the highpoint in patient

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<sup>10</sup> See for example *Canterbury v Spence* 464 F.2d. 772, 784 (Robinson J), „It is the clear prerogative of the patient ... to determine the direction which their interests lie“, *Chester v Afshar* [2005] 1 AC 134,[14] (Lord Steyn), „Individuals have a right to make important medical decisions for themselves“ and *Rosenberg v Percival* (2001) 205 CLR 434, 486 (Mason C.J., Brennan, Dawson, Toohey and McHugh JJ), referred to the right to information and explained that it „arises from the patient's right to decide for himself or herself whether or not to submit to the medical treatment proposed.“

<sup>11</sup> The description of the „backwards“ enquiry refers back to the Introduction to Part II of this thesis and a reference to Roger B. Dworkin, „Getting What We Should from Doctors: Rethinking Patient Autonomy and the Doctor-Patient Relationship“ (2003) *Health Matrix* 235, 283.

<sup>12</sup> *Canterbury v Spence* 464 F.2d 772, (1972), 784 (Robinson J).

<sup>13</sup> *Ibid*, 779.

autonomy and the definitive decision regarded 'informed consent' yet, the key question to be addressed when determining how best to protect the individual is, according to Robison J, whether or not the physician made a 'reasonable effort to convey sufficient information.'<sup>14</sup>

The enquiry purports to have the autonomous patient at its centre, but the real focus is on another individual. The discussion concerns what the doctor does and says with little, to no reference to the actual patient and their needs and desires. It would seem that autonomy here becomes an issue of professionalism and professional standards as opposed to individual patient needs and decision-making authority. This problem becomes even more complex when the discussion moves on to the question of causation. Then and the harm suffered (physical injury) is disconnected from the interest being protected (autonomy).<sup>15</sup>

In the United Kingdom, there has been a rejection of the language of informed consent. Duty of care is focussed entirely on the doctor and their professional standards which are, as outlined in Part I, set by professional peers. The particular patient remains curiously absent from the duty and breach stage of the enquiry and, despite some limited support for the approach taken in the United States,<sup>16</sup> the focus here starts and ends with the doctor's professional standard. The question asked is 'what information would a responsible body of peers have deemed appropriate?'<sup>17</sup> The test applied is confined to a consideration of clinical judgment regarding what

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<sup>14</sup> Ibid, 779, fn.15.

<sup>15</sup> This issue was initially explored in Part II (Chapter 8, with respect to *Canterbury*) and elaborated on in Chapter 11 where we explored the true nature of the loss sustained when insufficient information is provided.

<sup>16</sup> Refer Lord Scarman in *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Madusley Hospital & Ors* [1984] QB 493 and discussion in Chapter 3 regarding Lord Scarman's judgment in *Sidaway* under the heading Developing the Bolam test: Sidaway: Judgment: House of Lords (at [3.60]).

<sup>17</sup> This is a simplified statement of the „Bolam test“ which was taken from *Bolam v Friern Hospital Management Committee (Bolam)* [1957] 1 WLR 582, refer to Chapter 3 for detailed consideration of this test.

ought to be told to a patient<sup>18</sup> and the approach continues to be based paternalistically upon the view that the doctor really does know best with the prudent patient being a 'rare bird.'<sup>19</sup>

This approach did not sit comfortably with all of the Law Lords, demonstrated by Lord Scarman's strong dissent in *Sidaway* where he emphasised that the doctor's duty to inform arose from the patient's rights.<sup>20</sup> Lord Scarman has not been a lone voice of dissent: close reading of subsequent decisions reveals a discomfort with the accepted approach. There is a clear and firm position regarding duty and breach depending upon professional standards, but the absence of consideration of patient rights at the initial stage of the enquiry has led to a belated introduction of those rights during the causation discussion. This approach culminated in the curious conclusion of *Chester v Afshar*.<sup>21</sup> As outlined in Chapter 6 (see [6.90]), the Law Lords in *Chester* felt constrained by the parameters of the 'informed consent' enquiry and succumbed to the temptation, acknowledged in other decisions, to reach conclusions about responsibility based upon individual views of what ought to happen in the circumstances.<sup>22</sup>

It is clear, therefore, that in the United Kingdom there is a struggle between strict application of principle at the duty-and-breach stage of the enquiry and the considerations of the needs of the vulnerable individual patient who makes a belated, yet significant, entrance at the causation stage of the enquiry.<sup>23</sup> The breach question is clearly driven by considerations of medical

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<sup>18</sup> *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1984] QB 493, 517 (Dunn LJ).

<sup>19</sup> *Ibid*, 513 (Donaldson LJ).

<sup>20</sup> *Sidaway v Board of Governors of the Bethlehem Royal Hospital & the Maudsley Hospital & Ors* [1985] AC 971, 881-882 (Scarman, LJ).

<sup>21</sup> *Chester v Afshar* [2005] 1 AC 134, discussed in detail in Chapter 6 (at [6.70]).

<sup>22</sup> A temptation discussed and acknowledged by Lord Nicholls in *Kuwait Airways Corp v Iraq Airways Co* [2002] 3 All ER 209.

<sup>23</sup> This struggle is considered in Chapter 6.

professionalism as determined by other members of the same profession. It is a potentially biased exploration that has been justifiably criticised by the High Court in Australia.<sup>24</sup> Nor does it sit comfortably with all of the Law Lords, and perhaps that is why, as outlined in Part II, the discussion becomes infused with individual judges' notions of justice when the question of causation is addressed. In *Chester v Afshar* for example, autonomy is highlighted by all of the Lords once they turn their attention to causation<sup>25</sup> and it becomes relevant that the plaintiff/patient can be described as 'honest and innocent.'<sup>26</sup> Indeed, in an attempt to balance the scales, the enquiry becomes focussed upon the question of 'violated rights' as opposed to the all-important professionalism and behaviour of the doctor.<sup>27</sup>

Whilst the autonomous individual is present in, and important to, the process of determining causation, we see that once again there is no attempt to define what or who constitutes an autonomous individual. There is some progress made when Lord Steyn recognises a relationship between autonomy and personal dignity.<sup>28</sup> This does not, however, provide any real clarity as it is difficult, if not impossible, to build a logical bridge between a professional standard, unrelated to individual rights and the very personal concept of autonomy as reflected in personal dignity, which is, by its very nature, individuals. The result is an unwarranted leap across the gap between legal principle and individual rights to the conclusion that Ms Chester has suffered a wrong and therefore ought to recover.<sup>29</sup> What is the rationale behind this conclusion? It is to satisfy the essential purpose of the law, to right a wrong.<sup>30</sup> Such a leap would be unnecessary if a clear and defined model of both

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<sup>24</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 484-490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

<sup>25</sup> *Chester v Afshar* [2005] 1 AC 134, Lord Bingham (in dissent)[5], Lord Hoffman (in dissent) [28], Lord Steyn [14] and [24], lord Hope [56] and Lord Walker [92].

<sup>26</sup> *Ibid*, Lord Walker [101].

<sup>27</sup> This is clearly outlined in Chapter 6, see Manipulating causation: *Chester v Afshar* (at [6.70]).

<sup>28</sup> *Chester v Afshar* [2005] 1 AC 134, Lord Steyn [24].

<sup>29</sup> *Ibid*. Once again refer to the detailed discussion in Chapter 6.

<sup>30</sup> *Ibid*, [25]

autonomy (as proposed in Chapter 10) and loss (the loss of a right to make a choice based upon a complete map of paths to possible future selves, as outlined in Chapter 11) were to be adopted.

This conclusion is further supported by the approach adopted in Australia. The High Court begins the enquiry at a different place from the Courts in the United States and the United Kingdom. The incongruity of applying a peer driven professional standards test was recognised by the Supreme Court of South Australia in *FvR*<sup>31</sup> when King J suggested that practices adopted within a profession may be driven primarily by the needs and interests of the professionals rather than those of the individual clients (or in this circumstance, the patient). In recognising this, His Honour called for judicial as opposed to peer scrutiny of acceptable practice.<sup>32</sup> A shift in focus from the medical professional to the patient in determining what is appropriate would involve a clear rejection of the previously accepted *Bolam* principle, and this is precisely what occurred in *Rogers v Whitaker*.<sup>33</sup> As outlined in Chapter 4 (see [4.10], [4.20]), the High Court specifically rejected the *Bolam* test, describing it as ‘illogical.’<sup>34</sup>

The foundational decision of *Rogers v Whitaker* was discussed in Chapter 4 and it is from this decision that the materiality test emerged. The focus of the judicial enquiry shifted from the doctor to the patient and whilst it may appear that individual rights moved to the heart of the enquiry, the reality is that this is not the case. The test,<sup>35</sup> is about materiality and what would be significant to the patient. Whilst it is a rights and interest based approach, the Court rejected the language of autonomy and informed consent, describing it

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<sup>31</sup> (1989) SASR 189.

<sup>32</sup> *Ibid*, 193-194.

<sup>33</sup> (1992) 175 CLR 479.

<sup>34</sup> *Ibid*, 489 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

<sup>35</sup> Outlined in Chapter 4.



as 'amorphous' and 'apt to mislead.'<sup>36</sup> Despite the clear rejection of autonomy, similar themes to those raised in the other jurisdictions emerged. The discussion turned on the concept of meaningful choice (a concept I argue is central to autonomy) and the judgment of the Court indicated that meaning would grow from understanding and the provision of appropriate information. This information, described as material, is anything that would make a difference to that patient. Thus, at the conclusion of *Rogers v Whitaker* the position in Australia was rejection of the established tests of both the United Kingdom and the United States (which involved a focus on professional standards as defined by the medical profession and an embracing of the language of autonomy). The preferred approach was described as removed from concepts of autonomy and self-determination but involved a patient-centred enquiry about what information was needed. This of course raises the question, highlighted in Chapter 4 and explored in more detail in Chapter 10, of whether the rejection of autonomy and informed consent in *Rogers v Whitaker* amounted to a linguistic, as opposed to a practical distinction from the tests in the United Kingdom and the United States of America.

The implications of employing the language of autonomy and creating a test based upon the so-called autonomous individual were clearly identified by the High Court and *Rogers v Whitaker* heralded an apparent retreat from the position adopted in other jurisdictions. Despite the care taken to establish a unique test, removed from considerations of individual autonomy however, *Rogers v Whitaker* has perversely come to be interpreted and applied as a decision about individual rights and practical application of the theories of

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<sup>36</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

autonomy.<sup>37</sup> As we saw in Chapter 4, this subsequent interpretation of the decision in *Rogers v Whitaker* is not limited to inferior Courts. Members of the High Court have described the rule regarding materiality as a recognition of individual autonomy and as an Australian adoption of the *Schloendorff* principles.<sup>38</sup>

The concept of autonomy was therefore purportedly rejected by the High Court. This apparent rejection was, however, relatively short-lived and autonomy has subsequently been accepted as a valid consideration by the High Court. Indeed, the autonomous individual sits at the heart of the causation enquiry with Australia being the only jurisdiction of the three under consideration, to adopt a subjective test for causation.<sup>39</sup> The underlying rationale of the subjective test is an acknowledgment that only the individual before the Court can truly say what would have been significant to them and what would have made a difference in their decision-making process. As outlined in Chapter 7 however, it does not follow that the Courts accept the plaintiff's assertion that they would not have proceeded with the course of treatment, merely because they say so (and indeed, in 4 jurisdictions plaintiff evidence to this effect is legislatively excluded). In short, the Court recognises the risk of 20-20 hindsight and treats the evidence, which they specifically seek, with a level of scepticism which is almost contemptuous.<sup>40</sup> Where permitted, individual evidence is invited and encouraged and then, more often than not, rejected as being coloured by experience and hindsight.

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<sup>37</sup> D.Chalmers and R.Schwarz, „Rogers v Whitaker (1992) 175 CLR 479 and Informed Consent in Australia: A Fair Dinkum Duty of Disclosure“ [1993] 1 *Medical Law Review* 139, 145. See also the discussion in Chapter 4: The scholarly view of *Rogers v Whitaker* (at [4.70]ff), and specifically footnotes 62, and 65-74.

<sup>38</sup> *Rosenberg v Percival* (2001) 205 CLR 434, 480 (Kirby J).

<sup>39</sup> For a detailed analysis of this refer Chapter 7.

<sup>40</sup> This is discussed in some detail in Chapter 7. See also *Rosenberg v Percival* (2001) 205 CLR 434, [16] where Gleeson CJ refers to the „prism of hindsight“ which alters the focus of the plaintiff and [156] where Kirby J noted the „inherent unreliability of self-serving testimony.“

In Australia therefore the autonomous individual is evident at the edges of the breach enquiry but is central to discussions about causation. In practical terms, as we saw in Chapter 7, the impact of the plaintiff's evidence is often negligible. This is mainly because the physical condition of the plaintiff, and their vulnerable status at the time of the decision-making, means that the Court is unable to conclude that they would have rejected the treatment. It is only in the rarest of cases that a patient, like Mrs Whitaker, is able to satisfy the Courts that the material information would in fact have changed their treatment decision. Once again therefore we have the extraordinary situation of the rights which attend concepts of autonomy being subrogated to considerations of external factors.

A significant issue highlighted in this summary of the identified deficiencies in 'informed consent' is the issue of causation. Part II of this thesis highlighted the significant problems with the attempts by the Courts across all three jurisdiction to link the failure to inform with the subsequent manifestation of a physical harm. At the causation stage of the enquiry there is a clear line drawn between information which the Court recognises as material and that which would have made a difference to the decision-making process. Information which is clearly identified as significant to the patient (on either the subjective or objective test) will not always alter the treatment path. Therefore, individuals who walk a particular treatment path on the basis of incomplete advice find that there is no recognition of the impact that the denial of information can have. The Courts are prepared to conclude that the information ought to have been more complete and that the patient embarked on a journey for which they were ill-prepared but the enquiry stops there. The law links the lack of information to a completely unrelated physical outcome and, unsurprisingly finds (in most instances) that there is a lack of causative link. This is described as unsurprising because

there can be no causative link between two events that are logically unrelated. There is clearly a need to retreat from the doctrine of 'informed consent' and move towards a more meaningful approach that will bridge the gaps identified here.

### **The way forward: Informed choice**

[12.40] The doctrine of informed consent is built on flawed foundations. The doctrine in its current form is aimed at protecting the autonomous decision-maker but fails to define autonomy. The interest protected by the doctrine, that is the individual interest in making choices, does not factor into the enquiry. And crucially, it entails the complex mixing of two quite distinct considerations: negligence (standard of care) and consent (trespass). This thesis has carefully sifted through the plethora of judicial and scholarly discussions regarding 'informed consent' and has concluded that the ongoing debates regarding appropriate tests for standard and causation mask the true flaw in the doctrine. An important conclusion is that despite the apparently divergent paths travelled by the judiciary in the three jurisdictions under consideration, the reality is that all three usually arrive at the same destination which is, more often than not, denial of the plaintiff's claim. A consistent starting point in all three jurisdictions is the assertion of the individual right to information and it is this right that is then put to one side later in the negligence enquiry. If there is to be a meaningful protection of the right to information this interest must be a primary consideration and the trespassory notion of consent must be put to one side in favour of choice.

This argument intentionally puts the issue of damages to one side. As indicated in earlier discussions (both in the introduction and in Chapter 11), this discussion stops at the boundary of identifying a loss. Issues regarding damages and the appropriate measure of damages are beyond the scope of this thesis and would be determined by the Courts. Specific consideration of

autonomy is, however, essential. To give true meaning to 'informed choice' however we must begin from a clear, purposive definition of autonomy. The model most consistent with the ideal of choice is that of narrative autonomy. Here we could see the self-authoring individual empowered through the provision of appropriate knowledge to choose between possible future selves in a meaningful way. Whilst the journey of this thesis has been a long and involved one it is ending at a point first introduced by the High Court (and then largely ignored) in the key decision of *Rogers v Whitaker*. The proposed model would represent a shift away from the 'meaningless choice' that a patient makes when material information is withheld.<sup>41</sup> A legal model based upon narrative autonomy and choice would result in a meaningful consideration of pre-treatment advice: informed choice.

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<sup>41</sup> *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

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