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SYDNEY UNIVERSITY MEDICAL SOCIETY

LAMBIE-DEW ORATION 1984

WEDNESDAY, 25 JULY 1984

1984 : MEDICAL WATERSHED?

July 1984

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Hon Justice MD Kirby CMG
Chairman of the Australian Law Reform Commission

LAMBIE AND DEW IN 1984

It is a great honour to be invited to deliver this Oration. Particularly is it so in the first year of the second century of the University of Sydney Faculty of Medicine. My acquaintance with the distinguished professors after whom the series is named was greatly enhanced by the presentation to me of the Centenary Book of the Faculty.¹ It was given to me for a speech delivered in Adelaide for the Royal Australasian College of Physicians. Orating is a reliable, if somewhat arduous, way of building a library.

There would still be some who remember Professors Lambie and Dew. But they would be a declining number. Professor Lambie was still Professor of Medicine when I came up to this University in 1956. But he retired that year, having served from 1930. Professor Dew also held his post from 1930 to 1956 and over the greater part of his service was Dean of the Faculty of Medicine. The world in which they built this Faculty was a very different place. Charles Lambie, typically enough, was the son of a commanding officer of the Trinidad Light Infantry Volunteers. He was actually born, in the apogee of Empire, in Port of Spain, Trinidad. He was a brilliant student and happily survived service in the British Army in France in the First World. In 1922 he became the first person in Europe to use insulin for the treatment of diabetic patients.² His early research work was also distinguished. In 1929 he was offered the choice between the Chair of Medicine in Aberdeen and the GH Boscch Chair in Medicine at Sydney. Fortunately for Australia, he chose Sydney. He became the first full-time academically trained Professor of Medicine in Australia. By the end of 1932 he and Professor Dew had virtually recast the curriculum. Their course of medical studies remained largely unchanged until 1973 when the five-year curriculum was introduced.

Harold Robert Dew was almost the exact contemporary of Lambie. But he was born in Melbourne. After service in the First World War he became Acting Director of the Walter & Eliza Hall Institute. While at the Institute he wrote two notable monographs, one of which was Malignant Disease of the Testicle.³ He was appointed in 1930 to the Bosch Chair of Surgery at the University of Sydney, becoming the first full-time Professor of Surgery to be appointed in an Australian University. He was knighted in 1955. He died in 1962, the year after Lambie.

These two men, with lives almost exactly in parallel, contributed greatly to the distinction of this Medical Faculty. But more important, through imparting knowledge to successive generations of young medical students — year after year of the cream, the educational intellect of our schools — they passed on techniques and abilities that helped cure disease and relieve pain among millions of our fellow citizens. It is in this way that the ripple effect of skilful and dedicated medical education has a lasting impact on the society it serves.

Some might say — cynical and therefore in tune with the times — that it is aimless to celebrate two such Professors, dead for almost a quarter of a century. What possible relevance can their life's work have for us in 1984? The answer to that question is to be found in the history and traditions of English-speaking people. Their genius lies in building institutions which outlive individuals. Lambie turned his back on a Chair in Scotland, where he had cultural and family links. Instead, in the mood of imperial confidence, he elected his service in Australia. Dew taught with 'vigour and clarity' that was 'immensely impressive to under-graduate students'.⁴ Dew was especially interested in cancer. Lambie, being a Scot and trained in Edinburgh, brought thoroughness to his attention to detail, which was second nature to him.⁵ According to an obituary, he stressed the importance of careful history-taking and complete physical examination. He recorded his teaching in this field in a book, co-edited with Jean Armytage, titled 'Clinical Diagnostic Methods'. This book, according to Sydney University Medical Journal, was 'almost frightening in its attention to detail'.⁶

These two Professors had to deal with many problems during their time of service. These included the unrestricted entry in the Faculty, the problems of war and post-war reconstruction and then the imposition of quotas and limitations. They provided a splendid centre of teaching and learning and a tradition which the Faculty maintains to this day. In a sense, this is their lasting memorial. It can be said of them, as of Christopher Wren: if you look for their monuments — look around.

TO THE WATERSHED : OF TRANSPLANTATION AND UNWANTED BIRTHS

I have titled my Oration '1984 — Medical Watershed?' It is impossible nowadays not to recognise how many medico-legal questions of a moral character are pressing upon law, medicine and society. In response, the law and medicine have usually exhibited diffidence and uncertainty. Each discipline has reflected divisions of opinion in the community at large. The intractable nature of bioethical problems is admitted by most observers who turn their attention to them. No issue has caused such sharp and deeply felt division as that of the law relating to abortion. At the other end of the spectrum is the debate that initially brought the Australian Law Reform Commission into the bioethical sphere. I refer to the work of the Commission on human tissue transplantation.⁷ The Commission's report had to grapple with a number of the very difficult issues which are presented when medical science overcomes the normal tendency of the human body to reject transplantation of organs and tissues of another.

Justice Windeyer in the High Court of Australia once said that the law marched with medicine 'but in the rear and limping a little'.⁸ Nowadays this observation seems positively charitable. The common law of England, inherited in Australia, offers no rule or principle for dealing with such difficult modern problems as transplantation of human organs and tissues, in vitro fertilisation and ex utero transfer of the human ovum, artificial insemination generally, genetic engineering and so on. There is a simple reason for this. Until recently, the legal problems posed by these developments did not have to be confronted. Indeed they were not thought of or, if contemplated at all, they were regarded as improbable. In the case of transplants, the body's immunology rejected the process. In these circumstances, it is not a matter of criticism that the law gave no thought to the question of operations on donors for the positive removal of healthy, non-regenerative tissue. The law gave no thought to the conduct of intrusive surgery, not for the cure of the donor but for the relief of some other, third person. Likewise, the routine taking of organs from a dead human body was scarcely considered. At most, the law recognised only a limited right to property in a dead body. It offered few rules only about the rights and obligations of the legal personal representative, relatives or others with respect to it.

In the course of inquiry into transplantation it emerged that suitable 'donors' of viable organs and tissues (such as kidneys) were often young, otherwise healthy patients brought into hospitals frequently after motor car accidents and with massive brain damage.

In these cases, blood circulation is maintained for a time by the use of artificial, mechanical means, until a decision is made to terminate this external support. The law tends to conceptualise 'death' as an instantaneous phenomenon. Medical science shows that death is a process.⁹

Before artificial ventilators were developed, the classical criterion for determining death was the cessation of respiration and circulation of the blood. Interpose an artificial ventilator in a modern hospital and these criteria became not only irrelevant but potentially mischievous. In the English case, R v Potter¹⁰, a man stopped breathing fourteen hours after having been admitted to hospital with head injuries sustained in a fight with the accused. He was connected to an artificial respirator for 24 hours, after which time a kidney was removed and transplanted. The respirator was thereafter disconnected and there was no spontaneous breathing and heartbeat. At the coroner's inquest, the question arose whether the accused had caused the victim's death. Medical evidence showed that the patient had no hope of recovery from the brain injury. The coroner's jury found that the removal of the kidney had not caused the patient's death. It returned a verdict of manslaughter against the assailant. He was then committed for trial but was later found guilty only of common assault. The unsatisfactory features of this case left many lawyers with the conviction that the common law should be clarified to make it plain that death may be determined by reference to irreversible loss of function of the brain. The Australian Law Reform Commission proposed this in its report. Its proposals, in this respect, have been accepted in law in all States and Territories of Australia save Tasmania.

Many other contentious questions had to be faced by the Australian Law Reform Commission in its transplant inquiry. I list some of them to indicate the sensitive and difficult issues which law reform must address in the medico-legal area:

- . Should consent be required for donations at death, unless a person has, in his lifetime, registered an objection? The law of France and some other countries has recently adopted the latter approach.
- . Should the same legal regime cover transplantation of human spermatozoa and ova or is the transplantation of human life itself in a special class requiring legal treatment separate from the transfer of a kidney, cornea and other non-regenerative human tissue?
- . Should a child, in any circumstances, be permitted to donate a non-regenerative, paired organ to a sibling? Or should the law absolutely forbid this to protect the family and a young person from facing such a dilemma, even though the consequences of such an absolutist stand may be the death of a member of the family for non-availability of an organ suitable for transplant?

- . Should coroners be empowered to give pre-death consent to tissue removal?
- . Should the present retention of pituitary glands, removed from bodies at autopsy, be legitimised, because of the great social benefit that ensues in the treatment of dwarfism and other conditions from the use of the hormone extracted from such removed discarded tissue?

These are some only of the sensitive, controversial questions forced upon our society by the sudden advent of transplant surgery. The law, which is supposed to state society's standards, was left behind. In confronting these questions, the Law Reform Commission adopted its usual processing of exhaustive consultation. It turned to a team of consultants drawn from the medical profession in all parts of Australia. It added to this team moral philosophers and theologians of different traditions. Public hearings were held in all parts of the country. A consultative document was issued and widely discussed. The media was engaged in the debate. Millions of Australians heard the issues thoroughly and soberly explored before television and radio.

In the end, the Commission delivered a report¹¹ with draft legislation. The British Medical Journal, not frequently given to commenting on Australian legal developments, declared it 'the latest of an outstanding series'. Requests for the report have come from all over the world. Authority has been given for its translation into Spanish for use by governments throughout South America. I cannot recall to mind another case of a legal transplant from Australia to Hispanic America. Although Australian achievements on the international stage of medical research have been numerous, our equivalent achievements in legal theory and jurisprudence have been fewer. Times change.

I do not pretend that the Australian Law Reform Commission's report on Human Tissue Transplants is the last word to be written on the topic. But the unprecedented efforts taken to raise the perceptions of the legal and medical professions and of the lay community about the dilemmas which were posed in this particular area of operations ensured that its implications had been thoroughly debated and explored. Solutions were presented for the consideration of the lawmakers, who were helped to face up to issues that would otherwise be left in the 'too hard' basket. Those who value our institutions of lawmaking and who appreciate a society governed by laws not by the views of particular people (however sincere and talented they may be) will encourage the notion that we can find institutional means of helping the lawmaking process to face up to the legal and social dilemmas posed by modern technology, including medical technology.

That there is a need to do this is plain if we only pause for a minute to reflect upon the remarkable developments that we see almost daily in the press and upon which the law speaks, if at all, with a muted and sometimes confused voice. Take a few recent examples:

- . The Kentucky Supreme Court in the United States in 1983 decided that a man charged with assaulting his estranged wife and killing her 28-week-old foetus cannot be charged with 'criminal homicide' under Kentucky's Penal Code. The homicide statute did not define 'person'. However, it was held by the court that the common law rule should be maintained, limiting criminal homicide to the killing of one who has been born alive. The State of Kentucky had sought a ruling from the court 'in the light of modern medical advances and legal rulings in other contexts' that today a viable foetus should be deemed a 'person' for the purposes of the Kentucky murder statute. Two judges dissented. The majority adhered to the old common law principle.¹⁴
- . In Britain in 1983 a woman brought an action against the Health Authority running the hospital in which she had undergone a sterilisation operation. It was established that clips which should have been placed on her fallopian tubes were incorrectly located. She fell pregnant. She suffered anxiety during the pregnancy for fear the drugs she had been taken against pain could have harmed the unborn child. A normal healthy boy was born. She claimed that her measure of damages should include the increased costs to the family finances that the unexpected pregnancy had caused. The court held that it was 'contrary to public policy' and 'disruptive of family life' and 'contrary to the sanctity of human life' that damages should be recoverable for the costs arising from 'the coming into the world of a healthy, normal child'. Accordingly her claim for the costs of the child's upbringing to the age of 16 and enlargement of the family home was held to be irrecoverable.¹⁵

INCOMPETENT DIAGNOSIS OF CANCER

Take yet another instance which was reported in the Australian newspaper only last week.¹⁶ According to a report from London, a man dying from cancer hopes to make medico-legal history in Britain by suing the consultant physician whom he claims failed to tell him the truth regarding the nature of the disease from the start. Mr Peter Holtom, 48, former Managing Director of a publishing firm, reportedly plans to press his case to the High Court in England even though he may die before the case is heard. He has been told that he has only a few months to live. His 36-year-old wife says that if Holtom dies, she will carry on the action 'on behalf of all other patients who have the right to know about their own bodies'. Holtom says 'We expect to establish a legal precedent of the

greatest importance and significance'. According to the report he is bitter because he was told that he had a gastric ulcer and after drug treatment which appeared to succeed, entered hospital to have the ulcer removed surgically. He claims that no mention was made of stomach cancer. He says that had he been told of the doctor's suspicions, he would have refused surgery. The report goes on to record that Dr Michael Willoughby, the consulting physician at the Lister Hospital, has admitted that the hospital remained silent about the suspicions of stomach cancer, simply because the hospital staff waited until medical confirmation. Dr Willoughby said that the vast majority of patients with cancer know instinctively the nature of their illness but have no wish to discuss the possibility of terminal disease. According to the newspaper reports the doctor said:

It is one of the medical profession's greatest ethical dilemmas, because in practice doctors find that while some patients like Mr Holtom clearly wish to know that they have only a limited time to live, thousands of others do not.

Although it is probably true that this case in England is a rare instance of litigation involving a patient with cancer, and although such litigation is equally rare in Australia, the same is not true of the United States. One of the features of law journals coming out of that country in recent months has been the increasing attention paid to the possibility of medical malpractice suits for mishandling of cancer cases. In a recent issue of *Trial* magazine, a national legal news magazine in the United States, a medical writer, addressing the large audience of trial lawyers in that country, pointed out that the vast majority of people are either uninformed or misinformed about the prevalence of cancer, its curability and the nature and purpose of various cancer treatments. Specifically, the public markedly under-estimates the incidence of cancer in the population. On average the public believes that only one out of seven people will contract cancer. However, medical statistics indicate that the true incidence is about one in four. This does not mean that people are unaware of the widespread prevalence of cancer. They are highly aware of it. They are concerned about it. But the under-estimation suggests that a 'defence mechanism is at work helping people to avoid confronting their fears about cancer'.

The other misinformation relates to cancer mortality. Public surveys suggest that people are 'unduly pessimistic' about cancer mortality.¹⁷ On the average the public thinks that one out of five cancer patients survive. However, medical statistics indicate that for all types of cancers combined, about one out of three will survive ie will live as long as five or more years after diagnosis. The early treatment for cancer, doubtless as taught by Lambie and Dew, was surgery alone, or later surgery and radiation therapy.

Yet approximately 60% of all cancers would ultimately recur, thereby suggesting that they had not been completely removed. The disease had been pursued but not actually caught.

Many oncologists nowadays believe that combined adjuvant therapy with surgery and radiation therapy holds the best present opportunity for major successes in cancer treatment. But the key to success is usually early diagnosis. When diagnosed early, cancers are associated with fewer cells in total than when discovered late in their course. They are therefore more amenable to relatively complete removal. A delay of weeks or months increases the amount and frequency of metastases. Inevitably, this reduces the possibility of medical treatment to arrest the malignant disease.

It is around this concept that malpractice litigation involving misdiagnosis or failure to diagnose cancer in the United States has revolved.

Should a medical practitioner fail to detect cancer, treatment will be delayed and the patient's chances to recover will severely diminish. Furthermore the extent of surgery required will depend upon when the cancer is discovered. A cancerous mole, diagnosed in its early stages, can be readily excised. However, if the cancer grows, the removal of lymph nodes and other structures may be necessary in an attempt to save the patient's life. On the other side of the coin, if the doctor misdiagnoses cancer when the patient does not have it, the patient will suffer not only severe emotional distress but also, possibly, radical and even harmful treatment. This quandary exposes what Dr Willoughby has described as one of the recurring ethical dilemmas of the physician.

Negligence, in the United States, Britain and Australia, means much the same thing in the law. There must be a duty of care. There must be a breach of it. The breach must lead to consequent damage. In cases in the United States it has been made clear that delay in diagnosing a condition as cancer will not be actionable in the courts unless the delay is prejudicial.¹⁸ However, it has also been held that, if the delay results in an increase in the size of the tumour, however small, it will be sufficient to sustain the complaint of injury and damage.

In the United States, where litigation for medical malpractice is much more common than in Britain or Australia, a number of cases have come to the courts which illustrate the mistakes that can be made by medical practitioners:

- . A 16-year-old young woman was diagnosed after biopsy as having an innocuous growth on her upper jaw (maxilla). She received conservative curettage. Eighteen months and three recurrences later, each with the same microscopic diagnosis as the original, it was discovered that she had a low-grade malignancy requiring radical surgical excision. The entire maxilla and even a portion of the brain had to be removed, leaving the young woman grossly intellectually impaired. A review of the slides was then conducted. It revealed the identical pathology on all of the biopsies. Had a proper diagnosis been made on the first or even the second biopsy, the young woman would most likely have lost only a portion of the upper jaw and would have lived a normal and full life.
- . A 32-year-old man with a lump on the top of his tongue was told he had cancer. This diagnosis required radical surgery. His entire tongue, the floor of his mouth and both sides of the neck were removed. A later review of the slides revealed that the growth was a purely benign lesion requiring only simple local excision. The surgery to the patient could have been prevented had the pathologist sought consultation with another pathologists expert in the area.
- . A woman entered hospital for a biopsy specimen from her left breast. She claimed that her doctor had promised that no radical surgery would be performed unless there was a clear and absolute diagnosis of cancer. She was informed of an unequivocal diagnosis of cancer. A bilateral radical mastectomy was performed to remove both breasts. She later discovered that the diagnosis of cancer was incorrect. She only had a fibro adenoma.¹⁹
- . After consulting a number of physicians for eye problems, a female patient was diagnosed as having multiple myeloma. She was informed that she had a month to a year to live. Chemotherapy was commenced. It was stopped after a month due to the severity of side effects. Ultimately, the patient went to a cancer treatment for a second opinion. After 20 days of intensive testing she was told that she was experiencing only stress-related vision problems. She did not have a form of cancer. She should never have been subjected to chemotherapy.²⁰

Australian doctors might shudder at these cases. They would, most of them, express concern at the prospect of accountability for medical judgment in the courts. I can offer them many words of reassurance:

- . In Australia, as in the United States, a medical practitioner is not required to exercise the highest degree of skill and care possible in making a diagnosis. He or she is only required to use reasonable care and diligence and his or her best judgment.²¹

- Furthermore, liability does not arise where a misdiagnosis occurs as a result of an honest error of professional judgment, as distinct from a failure to do things or notice things that a reasonably competent medical practitioner would have done or seen.
- American patients are, in any case, much more litigious than their counterparts in Britain and Australia. There are many explanations for this. The United States is a more 'right-asserting' community. It is endlessly fascinated with submitting conflicts in society to the resolution of judges, juries and courts. In part this is a matter of tradition. But in very large part it is a matter of the differing cost rules that apply in the United States. These rules permit lawyers to accept a 'contingency fee'. This fee, which is, in most forms, unethical in Australia, permits the lawyer to accept a proportion of the prospective verdict as the reward for bringing the case. Usually in a trial the fee is approximately a third of the verdict. No win, no fee.

The American system of costs is condemned roundly by professionals in Australia, whether medical or legal. It is denounced as unseemly that professional people should be motivated in this way. On the other hand, there are arguments in favour of the American system:

- It is said to be the 'free enterprise answer to legal aid'. Certainly, it gets many more people to the courts to have their claims submitted to the umpire than we tend to do in Australia. One must ask the question whether the cases of misdiagnosis or failed diagnosis of cancer revealed in United States litigation ever occur in Australia. Of course they do. Mistakes, negligent and otherwise, are the constant companions of every professional person. But if this is so, whereas in the United States the patient received some compensation for the loss, what happens in Australia? Are the facts disclosed? Can expert evidence be secured against a fellow medical practitioner? Will a lawyer be found to bring the case? Will the judge or jury find there has been a lack of professional care? In default of such redress, the patient who lost his tongue or the woman who lost a portion of the brain or underwent unnecessary radical mastectomy would be left with a grievance, social security but not the salving balm of money damages.
- A second consideration was also mentioned by me in Adelaide, apparently to the astonishment of the assembled physicians. The ultimate aim of civil damages actions — known as medical malpractice in the United States — is not to provide punishment or a public pillory for the careless medical practitioner. It is to set standards of care that will be reached (for fear of being sued) and to provide a means for distributing losses in the community. This notion of 'loss distribution' was so novel that the noted medical broadcaster Dr Earle Hackett devoted an entire 'Body Program' broadcast to it.

Yet the aim of medical negligence cases is ultimately to ensure that those who can afford to do so (doctors and patients who are treated correctly) contribute to a fund from which those who suffer (patients who are incorrectly treated) can draw compensation for their losses. It is a simple insurance principle. It is a notion of switching funds to those who need it and can justly claim it. When this idea is perceived by medical practitioners, the exaggerated fears of medical malpractice suits in Australia will be diminished somewhat. True it is, we may not want the worst features of excessive litigation where minor claims can be dealt with adequately in some other way — through counselling, through peer review, through medical literature and professional experience. But these alternates may be scant comfort to the cancer victim or the non cancer victim who suffers a wrong diagnosis. Such a person may, with fairness, look to the community and its laws for a more substantial compensation and personal redress. In the United States, they do not look in vain.

Cases now coming out of the American courts, recorded in the literature, disclose the numerous instances in which the proper standard of care will be held not to have been reached. The cases illustrate situations where the medical practitioner has failed in the critical area of diagnosing the patient's cancerous condition with the thoroughness and attention to detail that Professor Lambie insisted of his students:

- . First, there is the failure to conduct a biopsy.
- . Then there is the failure to conduct an X-ray which, if conducted in a timely way, would have disclosed the existence of a cancer.
- . Then there is the failure to monitor the patient, after a working diagnosis included the possibility of a breast cancer. 'Wait and see' may be an appropriate approach in some cases but not after suspicion of a tumour.
- . Then there is the failure to identify tissues as malignant.

An important case involves the failure to inform. In Truman v Thomas²² a physician in California in 1980 told his patient that she should have a pap smear done. She refused. The physician failed to inform his patient of what could result from the refusal. Later, cancer was diagnosed. The court held that where a patient indicates a refusal to undergo a risk-free test or treatment, the physician is obliged to advise the patient of all material risks of which a reasonable person would want to be informed before deciding not to undergo the test or treatment. It was held that the medical practitioner had not gone far enough in the facts of that case.

- . Then, there is failure to consult, particularly where there are conflicting pathology reports.

- . Failure to render an accurate diagnosis in a pathology laboratory has resulted in a verdict for the estate of the patient who subsequently died.
- . As has been pointed out, failure to render an accurate diagnosis and causing emotional distress by a misdiagnosis of cancer can also result in significant awards of damages against the medical practitioners involved, particularly where the patient undergoes radical treatment or is disrupted in work and family life by reason of a misdiagnosis.

In many of the cases in the United States, where the medical practitioner's negligence results in a belated diagnosis of cancer, the defence usually contends that even if the cancer had been diagnosed earlier the patient would have died anyway. A few years ago this was a more viable argument than it is today. There has been great progress made in the treatment of cancer. If the condition is caught in its earliest stages, the prognosis for a complete recovery in the case of at least some cancers is relatively high. But even if the cancer had progressed at the time of the original misdiagnosis and the medical practitioner should have discovered it, a patient will still be able to recover for the diminished chance of survival or shortened life span resulting from the misdiagnosis. This will be a relevant loss suffered as a result of breach of the duty of care. Similarly, if more serious and radical treatment than otherwise would have been necessary is required because of a late diagnosis, the patient will be entitled to compensation for this. One American court put it thus:

Plaintiffs only have to show by believable evidence that the erroneous diagnosis caused [the deceased] to fall from the category of persons who would statistically have been expected to survive to a category in which there was almost no chance of survival. This is all that could reasonably be expected of plaintiffs. To prove that she would not have died otherwise is an unreasonable burden.²³

Commenting on these American cases, Dean Ronald Gerughty, Dean of the College of Health Related Professions in the Idaho State University, concludes:

The diagnosis of cancer in a person is no longer the automatic death sentence it was once thought to be. Nevertheless the word "cancer" still conjures visions of helplessness, hopelessness and defeat in most people. With an early diagnosis, the chances for a complete recovery are considerably greater than several years ago. The jury must be made aware of the fact that cancer is not necessarily a death knell. Plaintiffs counsel must replace ignorance with accurate information to ensure that the jury understands the harm caused by misdiagnosis or late diagnosis of cancer.²⁴

Australian lawyers and doctors will be watching closely the outcome of the case in England involving Mr Peter Holtom. His assertion of the 'right to know' is an assertion of the basic right of all patients. It must never be forgotten by every physician or surgeon that the law upholds the integrity of the patient. Without the consent of the patient any medical procedure is an unlawful assault. Great care must be taken to secure that consent. One of the greatest changes that has come over medicine since the days of Lambie and Dew has been the special attention now being paid to the issue of informed consent. In a community that is better educated and better informed, including about medical and legal matters, it is appropriate and necessary for more time to be spent with the patient explaining the risks, dangers and necessities of alternative medical treatments. The days of the 'God Professor' probably passed with Lambie and Dew. The days of the patronising authoritarian medical practitioner have also gone. Patient autonomy is the guiding star today. Though the law does not require cruel, blunt and insensitive confrontation and does not require insistence upon communicating information which the patient is beyond understanding or does not wish to hear, it is clearly best to err on the side of imparting information critical to the patient. That is why so much attention is now being paid to patient consent. Any medical practitioner who believes that a simple form signed on admission to hospital absolves him or her from the obligation to explain and secure a knowing patient consent for serious treatment is indulging in a dangerous self-deception. Practitioners who believe that a patter of words, repeated quickly in stressful and emotional circumstances, is adequate to secure informed patient consent is likewise in error. In the age of mass production, of hurry and rush, the medical practitioner may be one of the last craftsmen. But he or she works with the most precious of clay and the legal and moral duties are commensurately great.

MEDICAL ETHICS

If one takes the cases I have mentioned, there is a clear lesson for medical education which, I believe, Lambie and Dew (were they here) would warmly applaud. The cases of human tissue transplants, abortion and cancer diagnosis are only some of the quandaries that are now pressing upon the medical practitioner today. There are many others. There are debates on such matters as:

- . substitution of a 'quality of life' test for decisions on the removal of life support systems;
- . ethical issues on the implantation of an artificial heart;
- . the claim of history to the disclosure of medical details about famous people;

- . the refusal of medical intervention in the case of children with major handicaps;
- . vivisection of aborted fetuses in order to supply tissue specially useful for experimentation and transplantation;
- . the right of severely handicapped patients to die, and in the event of gross disabilities, to have the assistance of medical staff to die if they so wish;
- . the control of gene splices;
- . advertising in the popular press for surrogate mother volunteers;
- . the suggested extension of cloning from animals and plants to the human species;
- . the possible development of hybridisation as between species, including human beings.

Some of these issues have already been addressed in the courts, especially in the United States. But Australia will not be immune from them. Medical practitioners often have to make extremely difficult decisions which affect the life and death of fellow human beings. Yet very little emphasis is placed upon these questions in either medical or legal education in Australia.

We talk of 'universities' as if they were truly a place for a universe of disciplines together. Perhaps in the far-off days of 1930 when Lambie and Dew came to this university, it was so. Perhaps they joined Professors of Philosophy and Engineering over lunch in the Union and discussed the quandaries of their various disciplines. But university people today, at least in Australia, tend to live highly compartmentalised lives. Medical students rarely meet law students. Indeed, in this University the law students are, for the most part, actually banished from the campus in order to begin the process that will place them safely in their legal cocoon. There is inadequate dialogue between the disciplines. Yet new technology is forcing us together again, as in the ancient universities. The computer and its implications for monitoring medical patients will bring together the doctor and the computerist. Genetic engineering and in vitro fertilisation will bring together the doctor, the philosopher, the theologian and the lawyer. We should encourage this process. It will release us from the blinkers of our narrow training and the sheltered perspective we have had of complex problems.

The two fine Professors whom we celebrate tonight would, I believe, expect us to address the issues I have recounted. Doubtless they would be puzzled by the developments of in vitro fertilisation, the prospect of human cloning, the marvels of genetic manipulation, the experiments on foetal tissue and the triumph of transplantation. But I believe they would share with me a concern as to whether our institutions, the traditional vehicle of English-speaking people for solving problems, will cope with

the number, sensitivity and urgency of the problems now presenting to medicine and society. Will our Parliaments have the wit and will to address quickly enough the quandaries being presented by medical technology? Will the courts have the skills, the knowledge and the common sense to tackle justly the urgent claims that are brought to their doors? Will the courses of instruction in the universities be adequate to alert the generation of today (many of them growing up without the anchor of religious belief) so that they have a moral framework to which they can refer in making consistent moral choices? These are the institutional questions we should ask. It is because they have not been answered that 1984 is a watershed in medicine.

FOOTNOTES

1. University of Sydney, Faculty of Medicine, Centenary Book of the University of Sydney Faculty of Medicine (ed J Young & Ors), 1984.
2. ibid, 367.
3. 1925, id, 382.
4. J Loewenthal, Obituary of Emeritus Professor Sir Harold Dew, Sydney University Medical Journal, 1963, Vol 52, 15.
5. Obituary of Professor Charles George Lambie, Sydney University Medical Journal, 1962, Vol 51, 11.
6. ibid.
7. Australian Law Reform Commission, Human Tissue Transplants (ALRC 7), 1977.
8. Mt Isa Mines Limited v Pusey (1971) 45 ALJR 88.
9. ALRC 7, 52.
10. Unreported, but see Times, 26 July 1963 and Medico Legal Journal, 31, 1963, 193. Discussed ALRC 7, 58.
11. See ALRC 7, 43.

12. ALRC 7. A draft Transplantation and Anatomy Ordinance was attached. It forms the basis of the Australian legislation enacted.
13. British Medical Journal, 28 January 1978, 195.
14. Hollis v Kentucky, 33 Clr L 1005 (1983).
15. Udale v Bloomsbury Area Health Authority [1983] 1 WLR 1098.
16. The Australian, 13 July 1984, 3.
17. Anon, 'Well it's cancer — so what's the use', Trial, May 1983, Vol 19 No 5, 62, 63. The author is described as 'an active clinician in oncology' who received his MD from Johns Hopkins Medical School and is certified by the American Board of Internal Medicine with sub-specialties in hematology and oncology.
18. Speer v United States, 512 F Supp, 670 (ND Texas 1981), affd 675 F 2d 100 (5th Cir) 1982.
19. Williams v Cordice, 100 Misc 2d 425, 418 NYS 2d 995 (1979).
20. Blanchfield v Dennis, 438 A 2d 1330 (Md 1982).
21. Lauro v Travelers Insurance Co, 261 So 2d 261 (La App 1972).
22. 27 Cal 3d 285, 611 P 2d 902, 165 Cal Rptr 308 (1980).
23. Hunter v Office of Health Services Inc, 385 So 2d 928 (La App 1980).
24. RM Gerugthy, Negligence in the Diagnosis of Cancer, in Trial, February 1984, Vol 20 No 2, 68, 80. The author acknowledges his reliance on the discussion and cases referred to by Gerugthy. The article contains many other cases worthy of attention.