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PRINCIPLES OF HEALTHCARE ETHICS: CONSENT AND THE DOCTOR/PATIENT RELATIONSHIP

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PATIENT CONSENT IN A CONTEXT OF HUMAN RIGHTS

As a sign of the changing times, witness the opinion of an elderly Scottish judge, ventured nearly a century ago, concerning a case brought by a patient against a doctor:

> *"This action is certainly one of a particularly unusual character. It is an action of damages by a patient against a medical man. In my somewhat long experience I cannot remember having seen a similar case before."*[1]

Times have certainly changed. Now it is common to read of the medical malpractice "explosion".[2] Even discounting the more exaggerated and alarmist claims which are voiced about this phenomenon, it is certainly true that many more doctors and other healthcare workers are taken to court today than was the case, even 40 years ago. What has happened in the past four decades to occasion this change?

Many explanations are given. They include the higher standards of general education enjoyed by members of the public, the consequential decline in the uniqueness of the position of professional advisers, and the tendency for unquestioning respect to be replaced by self-confident expectations of communication. So widespread is the public discussion of health, the latest drugs and technology and of alternative treatments, that it is by no means uncommon to find amongst lay people a general appreciation of healthcare issues which was certainly absent in earlier generations. To treat such patients with condescension and paternalism not only creates a feeling of resentment, it also minimises the opportunities for insightful discussion which may actually assist in diagnosis and in the treatment of the patient as a whole person, not just a person with a particular medical condition.

Everywhere around us we can see evidence of the changes which have come about as a result of these social and technological developments. They have occurred at different rates in different countries, in harmony with general political and legal movements. Around the world we laugh at the television series *"Yes Minister"*, portraying the wily British civil servant with his attitude "nanny knows best". In many countries, including my own, the previous theory of ministerial responsibility held by such arrogant bureaucrats has given way to a more accessible and effective means to render public servants truly accountable to those they serve. We had to borrow from Scandinavia the Ombudsman and notions of freedom of information to achieve this end. In the field of healthcare, the last few decades have seen much parallel attention to the provision of improved procedures for making complaints and rendering doctors and others accountable for professional misconduct and neglect.

Yet in both the northern and southern hemispheres, intensive inquiries have revealed that an abiding complaint of patients in developed countries, otherwise quite satisfied with their relationship with their doctors, is that they are not allowed to participate sufficiently in deciding about their treatment nor given enough information to enable them to do so. This was the finding of the United States President's Commission in 1982.[3]

On the other side of the world, it was confirmed more recently by an Australian study which showed that 13% of patient's complaints were about poor communication and 27% about poor attitude or behaviour on the part of healthcare providers.[4]

At the heart of the problem of consent and the doctor/patient relationship is the tension between the unquestioned need to respect the integrity and wishes of the individual patient (on the one hand) and the years of study and practical experience which go into the activities of medical diagnosis and treatment (on the other). Patients are infinite in their variety and in their inclination to know medical detail and in their capacity to understand it, if explained. Doctors and other healthcare workers are infinite in their variety as in their capacity for communication, their inclination to spend the time necessary and their conviction about its utility.

Here, then, is the problem. Is it not better, the skilful diagnostician and busy surgeon may ask, to get on with the job doing the best possible for the patient according to the highest standards of the medical profession? If you want communicators and public relations experts who will make patients feel better — go to a therapist or tune into talk-back radio. You can *trust* the doctor to act by the best standrds of his or her peers. Failure to do so will require an account to professional bodies and, possibly, in a civil action at law. Who knows what the patient would do if over-burdened with data about every conceivable risk of healthcare? Many patients would be frightened off beneficial treatment by exaggerating the risks and overlooking the far greater chances of benefit. So leave it to the professionals. Nanny knows best.

These arguments held sway in the common law of England until quite recently. They profoundly affected the approach of the courts of the many countries which derived their law from England. The principles stated were congenial to the judges who pronounced them. They reflected their own opinions about the circumstances in which other learned professions — including their own — should be rendered liable for want of care or want of communication to those seeking out their professional skills.

But the phenomenon of our age (apart from higher standards of education and technological advances) is the universal assertion of basic rights. In a sense, it is a natural outgrowth of the social change which occasioned the American and then the French revolutions 200 years ago. It was no accident that those revolutions were accompanied by constitutional statements asserting what were then called the basic Rights of Man. The impact of United States power on the world of the 20th century has helped to universalise this movement, with its roots as deep in English history as the *Magna Carta* of 1215 and the *Bill of Rights* of 1688.

The *Universal Declaration of Human Rights* was adopted by the General Assembly of the United Nations in 1948 in the aftermath of the Second World War. Its first article declares that:

> *"All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood."*

One by one, the succeeding articles of the *Declaration* confirmed this basic principle of universal respect for each precious individual human life. Article 3 promises everyone:

> *"The right to life, liberty and security of person."*

Article 5 declares:

> *"No-one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."*

In the special context of medical treatment, the horrors of medical experimentation in Nazi Germany propelled the international medical community to a restatement at Nuremberg of the ethical principles governing healthcare.[5] The Nazi Party had found sympathetic listeners in the medical profession. German doctors were not always the victims of the Nazi ideology, but often active and responsible agents, committed enthusiastically to its principles of racial hygiene. Such recent and frightening evidence of the errors that can occur when a great profession loses its way necessitated the return to a basic re-statement of the functions and limits of the doctor in relation to the patient. This takes the doctor, as it does any professional person, back to respect for the inviolable dignity of every human being, expressed in the *Universal Declaration of Human Rights* and the various other international, regional and specialist statements of basic rights which have been such a feature of the new world order developed around the United Nations since the Second World War.

It is therefore important to see the issue of informed consent as a tiny fragment of the mosaic of that order. One English Law Lord put it well:

> *"This illuminates the relationship between doctor and patient when they face one another. It is not fundamentally the expert instructing the ignorant, even though those terms may accurately classify the respective parties. One free human being advises and helps another. The relevant law exists for the purpose of supporting that relationship."*[6]

THE CHANGING APPROACH OF THE COMMON LAW

As a lawyer, I necessarily approach the obligations of the doctor (with whom I include other healthcare workers) to secure the consent of the patient with the aid of the formulae by which that obligation has been expressed in legal decisions. But the reader should not rush away thinking that what will follow is an abtruse summary of cobwebbed books containing obscure legal rules. What follows is, in fact, a reflection on legal decisions in particular cases where doctor and patient have faced each other in a courtroom.

There are, of course, dangers in writing in general terms about consent of the patient as perceived by the law. The law is bound to particular jurisdictions. Even between England and Scotland it will differ. Expressed by judges in the diverse societies of England, Canada, the United States, Australia and elsewhere, what is required will differ from one place to another and over time. Expectations of different societies, and within the same society at different times, will vary. Accordingly, the expression of what it is "reasonable" to expect of the doctor in securing consent from the patient will vary. The basic starting point of the law in all of the places mentioned (and far beyond where the common law is daily applied) will be the same. But contrary to mythology and perhaps popular expectation, the law on this subject is not set in stone. Indeed, it is in the process of development. Unsurprisingly, it reflects the social and technological changes to which I have referred. Lately, it has also come to reflect the attitudes to basic individual rights which are reinforced in national, regional and universal statements of individual rights such as those I have mentioned. Even where these universal statements do not apply as a matter of strict law, they provide the intellectual environment in which lawyers (including judges) operate, performing their daily work. Inevitably, they influence (even subconsciously) the

attitude that is adopted towards the rights of the individual patient and the duties of the individual doctor.

In some jurisdictions, the local parliament has enacted a law obliging the doctor to secure consent of the patient in order to avoid the risk of criminal prosecution for performing on the body of a patient an unlawful trespass.[7] But normally the obligation of consent, and the content and quality of the consent needed, depend upon the common law expressed by judges. Consent only becomes critical, in a legal sense, when the doctor is sued for damages or prosecuted for unprofessional conduct. In a moral sense, however, it is vital at all times to the relationship which is established between the doctor and the patient.

Very few cases, even of medical mishap, result in actions against a doctor. Fewer still come to court. Few indeed (viewed as a proportion of the medical procedures daily performed in their millions) are the cases leading to professional complaint. So it would be inappropriate to regard consent as only needed for cases falling within these relatively rare exceptions. The law states its standards. Although invoked rarely in a courtroom, such standards set the tone and nature of the relationship between the doctor and the patient. They pervade that relationship. That is why their content is so crucial.

The common law of civil wrongs is conveniently divided into various categories. When consent is important in the courts, it is usually because the doctor has been sued for a civil wrong or for breach of contract. But what is ordinarily claimed against the doctor is that he or she is guilty of trespass to the person or of negligence. Each of these wrongs is provided by the law, in part to ensure that remedies are available to a patient for wrongful conduct on the part of the doctor. If a doctor undertakes a medical procedure without the patient's consent, the doctor is guilty of an assault (a battery). In such a case, the patient can bring an action. If want of consent is proved, the patient can recover damages.

Until recently, it has been considered in most common law jurisdictions that actions of battery in respect of surgical or other medical treatment were confined to cases where no consent at all has been given or (emergencies aside) surgery has been performed or treatment given beyond that to which there was consent. More recently, however, as a reflection of the greater recognition of the fundamental right of the patient to control his or her own body and to give or withhold consent, courts have begun to go further. They have asserted that it is not enough that the patient has been told generally about the nature of the procedure:

> *The patient had a breast reduction operation to diminish the size and weight of her breasts. She was concerned that the operation would cause scarring. The doctor assured her that scarring was unlikely and, if it occurred, it would be superficial and soon fade away. She consented to the operation. In fact, the breasts were grossly and permanently scarred. The nipples were relocated unevenly. She complained of pain and lasting embarrassment. She succeeded in a claim for damages for battery as well as negligence. The court held that her consent to the operation was not a true consent because the doctor had not told her about the procedure and risks involved.*[8]

More usually, however, the patient's complaint is about the doctor's negligence. Even a complaint of breach of contract will typically import considerations of negligence because what is asserted is a failure by the doctor to observe reasonable care in treatment of the patient. In such cases there is often no complaint about lack of information or want or consent. The only complaint is that the performance fell below the standards

reasonably expected of a competent doctor. Failure to recover all of the swabs from an operation or the performance of an arthrodesis on the wrong knee are cases of this class.

An increasing number of cases are now coming before the courts where things have gone wrong and the patient includes, amongst the complaints, that the doctor did not provide full and adequate information about the nature of the operation and its risks. For a claim, so framed, to succeed two things must be shown:

- That the doctor's failure to disclose the information was unreasonable in the circumstances; and
- That this failure was the cause of the harm to the patient in the sense that he or she would not have consented to the treatment had a proper disclosure been made.

The second element is often difficult for a patient to prove in a court of law. The mere assertion by the patient will not prove that it was so. Such assertions are often coloured by a great deal of wisdom after the event. Judges and juries realise that. Hence, many such claims founder upon this principle. But sometimes the patient's assertion will be accepted. The question then is what is the test to be applied relevant to procuring a proper consent from the patient?

THE BOLAM TEST AND ITS CRITICS

Upon this question it is fair to say that the law is in a state of active development. Different answers to the question would be given in different countries. In England, the approach to be adopted was expressed in a passage of instruction to a jury in an important case of medical negligence. It became known as the *Bolam* test after the plaintiff who brought the case:

> *Mr. Bolam, a manic depressive, was given electro-convulsive therapy. A danger was of seizures which would cause fractures of the patient's bones. Measures such as restraint and the provision of relaxant drugs reduced those dangers but Mr. Bolam was given neither. Nor was he routinely warned of the danger of fracture or the availability of relaxants or restraints. He did not ask about these things. In the course of his therapy he suffered severe fractures of the pelvis and sued the hospital. Following Justice McNair's direction to the jury, Mr Bolam lost.*

The critical passage in the judge's direction to the jury, stating the law, was:

> *"[The doctor] is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art..... Putting it the other way around, a man is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion which would take a contrary view."*[9]

This test has been repeatedly criticised as just another illustration of the "nanny knows best" attitude which has hitherto permeated English law and society. A recent critic in the United Kingdom itself has asserted that it provided the greatest obstacle to successfully suing doctors in negligence because it effectively allowed them to set their own standards of care. A doctor could not be found negligent so long as he or she had acted in accordance with the practice accepted as proper by "a body of medical men".[10]

In the United States, a different principle was long accepted. Doubtless this was so because the courts approached the matter with a less tender concern for the protection of the doctor, when sued, and with a greater appreciation of the fundamental right of the patient to make informed decisions about medical procedures affecting his or her body. This different attitude almost certainly derived from fundamental differences which exist (despite the unity of the common law) between the conception of the individual in society on the opposite sides of the Atlantic. A reflection of this difference is also seen, as Professor Giesen points out, in the modern European law on this topic.

Years before *Bolam*, Justice Cardozo in the United States laid down the basic principle which has permeated American law on this topic:

> *"Every human being of adult years and sound mind has a right to determine what should be done with his own body."*[11]

Upon the basis of this different starting point, American courts have repeatedly upheld the patient's right not to be given medical tests or treatment without informed consent. A patient has the right to be informed about the nature and implications of proposed procedures. The patient must be told of the material risks, complications and side effects. Without such information the patient is considered incapable of giving the consent necessary to authorise the medical procedure.

Defenders of this principle assert that it is less paternalistic, more respectful of individual bodily and spiritual integrity, more likely to promote the remedy of the constant complaints of lack of communication which bedevil the doctor/patient relationship and more likely to result in better medical procedures, based upon a fuller appreciation of the patient's viewpoint. Critics, on the other hand, suggest that it results in defensive medicine, posits a fundamental lack of trust between patient and doctor, confuses patients unnecessarily with detail they do not want or need, bombards them with information they cannot fully understand, alarms them needlessly about risks that are remote and takes up a great deal of time which could be better spent actually treating patients rather than talking to them.

In Australia, there has been a gradual shift away from the *Bolam Test*. In a leading case in my own Court, the new rule was laid down:

> *"It is not the law that if all or most of the medical practitioners in Sydney habitually fail to take an available precaution to avoid foreseeable risk of injury to the patients, then none can be found guilty of negligence."*[12]

This approach has also been followed in South Australia where the courts have refused to surrender the standards required to the practices of the medical profession. It is for the courts, representing the community, not doctors, to lay down the reasonableness of what should, or should not, be disclosed to a patient. The reason for this stand was explained:

> *"In many cases an approved professional practice as to disclosure will be decisive. But professions may adopt unreasonable practices. Practices may develop in professions, particularly as to disclosure, not because they serve the interests of the clients, but because they protect the interests or convenience of members of the profession. The court has an obligation to scrutinize professional practices to ensure that they accord with the standard of reasonableness imposed by the law. A practice as to disclosure approved and adopted by*

a profession or section of it may in many cases be the determining consideration as to what is reasonable. . . . The ultimate question, however, is not whether the defendant's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law. That is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community."[13]

In England more recent decisions have included a stern defence of the *Bolam* test, but also telling criticism of it, notably by Lord Scarman.[14] The cases have not however finally settled the controversies about the *Bolam* test because of the state of the evidence before the courts. Lord Scarman, with the benefit of a detailed review of the United States and Canadian legal authorities, preferred the adoption in England of a test expounded by the United States Court of Appeals.[15] This test enunciated a number of propositions. The first of them was:

"The premise is the concept that every human being of adult years and of sound mind has the right to determine what shall be done with his own body. The informed exercise of a choice, that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The doctor must therefore disclose all material risks."

In the way of the law, Lord Scarman's dissent on this point of informed consent has greatly influenced the development of the law in Australia. It has been preferred to adherence to the *Bolam* test and the majority view in the English House of Lords favouring its continuance.[16] Not all Australian commentators applaud this trend away from *Bolam*.[17] But I do.

The problem with the old test is that it is, in reality, a relic of an earlier time and of earlier ideas of the proper relationship between doctors and patients. The notion that doctors know best and that, by the standards of their profession, they can determine what patients ought to know, turns the nature of that profession on its head. It is not there for the good of doctors. It is there for the benefit of patients. The only authority and legitimacy of the doctor to intervene in the life and body of the patient is, respectful of the patient's individuality, with the patient's informed consent. That is why a proper development of the law, reflecting the age of basic human rights in which the law now operates, will start at the other end of the equation of consent, just as the Americans do. Ask not what your doctor can do for you. Ask rather what you agree should be done to you with your informed consent.

EXCEPTIONS AND CONCLUSIONS

In the nature of a brief discussion of consent in the doctor/patient relationship it is impossible to review the vast body of literature on this topic deriving from the courts, academics and universities. Law reform bodies have emphasised that the best foundation for the proper development of an appropriate relationship between doctors and patients is to be found not in general expositions of legal or moral principles, but in what actually happens in the doctor's surgery or the hospital casualty room or operation ward.[18] We may find that what is actually happening in the dialogue between doctors and patients is rather different, when the empirical data is examined, from what we have assumed. So it was found in the case of police stations in their treatment of criminal suspects, although I would not wish to extend that analogy.

Whatever the law says, and moral precept requires, there will always be limits upon the amount of information which a doctor can press upon a patient. These limits will

depend upon:

- The personality and temperament of the patient and the patient's attitude to receiving such information.
- The patient's actual and apparent level of understanding.
- The nature of the treatment. Obviously the more drastic the treatment the more information will be required.
- The magnitude and likelihood of possible harm, the incidence of risk and the remoteness of the chance that things will go wrong.

Because risk is the inescapable companion of any professional endeavour, and especially in the context of medical treatment, a realistic law will have regard to the crises which doctors daily face. The notion of imposing an obligation on the surgeon who discovers an unexpected problem in the midst of an operation, to sew up the patient and wait for a consultation is wholly unrealistic. So is the notion that a doctor must have express consent before attending to an accident victim or to someone suffering an emergency or in a state of unconsciousness. The variety of doctor/patient relationships, and of the problems which arise within them, are so great that care must be taken in expounding universal rules about patient consent. Nor is this an exhaustive discussion of the circumstances in which questions of informed consent may arise. Thus, I have not explored the possible need for a general no fault system of compensation for the victims of medical mishaps, such as is now available in New Zealand and in Sweden to obviate actions for damages when mistakes occur. Nor have I examined the particular issues that have lately arisen in the case of consent to medical treatment by infants and minors.[19] Or the special problems which have arisen in the context of screening patients for the AIDS virus.[20] The issue of consent in the doctor/patient relationship is one of great controversy, precisely because it is the very centrepiece of that relationship. It marks out the fundamental way in which the relationship will work.

So long as it is a relationship based upon perceptions of the profession's standards it will tend to continue in a condescending and paternalistic approach which is fundamentally inimicable to the rights of the patients and the proper limits of the intervention of the outsider, however skilled and however well intentioned. That is why the guiding star must come to be the express or imputed agreement of the patient to anything that affects a patient's life, body and psyche. With the great privileges of, and respect for, the healthcare professions go great responsibilities. The first may be to do no harm. But the second is to have to the greatest extent practicable the fully informed consent of the patient. The law, in varying degrees, demands it. Moral and ethical principles reinforce the law. Social and technological changes give new content to what law and ethics require.

Endnotes

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