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JOURNAL OF MEDICAL ETHICS

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Australia

For a very long time in this Australia (and still in England) the test to be applied for patient consent to medical intervention has been that laid down in a passage of a judge's instruction to a jury in an important case of medical negligence. It became known as the Bolam test, after the plaintiff who had brought the case. Mr Bolam, a manic depressive, was given electro-convulsive therapy. A danger was that 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 of these measures. Nor was he routinely warned about the danger of fracture or the availability of relaxants or restraints so that he could opt to have them applied to reduce the risk of injury to his person. Not unsurprisingly, being ignorant of these things, he did not ask about them. In the course of his therapy he suffered very severe fractures of his pelvis. He sued the hospital concerned. Following the direction to the jury by the trial judge, Justice McNair, Mr Bolam lost. The test stated in the trial judge's instruction to the jury was, however, upheld and applied by the English courts.¹ More recently it has been affirmed by a

majority of the House of Lords, the highest judicial court of the United Kingdom.² This is the test of the law as Justice McNair stated it to Mr Bolam's jury:

*"[The doctor] is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a reasonable body of medical men skilled in that particular art ... Putting it another 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 that would hold a contrary view."*³

The test stated in the Bolam case was criticized roundly both in the United Kingdom itself and in other countries of the common law which have inherited the English legal system. In fact, it was suggested that the test was simply a hang-over of the Victorian age when "Nanny" was supposed to "know best" In Australia, it was sometimes irreverently said that it grew out of the class system and hierarchical nature of English society and reflected the unwillingness of one profession (the law, represented by the judge) to countenance ordinary people challenging the rules laid down by another profession (medicine). It was also said that, effectively, it allowed the medical profession to set its own standards of care. A doctor could not be found negligent so long as he or she had acted in accordance with the standard accepted as proper by a body of competent medical practitioners.

In the United States, a different principle was long accepted. Doubtless this arose from the somewhat different nature of United States society. The law tends to reflect social differences in this way. Perhaps the United States law was influenced by the different class structure and less hierarchical nature of the society of that country and the greater scepticism that has long existed concerning the claims of learned professions to set the community's standards. The American courts looked at the issue with a larger appreciation of

fundamental right of the patient to make an informed decision
t medical procedures affecting his or her body. Justice Cardozo,
example, one of the great American judges of this century laid
the basic principle which has permeated the law of that country
his topic in the following aphorism:

*"Every human being of adult years and sound mind has a
right to determine what should be done with his own
body."*⁴

Upon the basis of this starting point, the United States courts
re repeatedly upheld the patient's right not to be given medical
sts or treatment without *fully informed* consent on his or her
rt for such tests or treatment. Absent such fully informed
nsent, the tests or treatment were unlawful. If harm resulted, the
tient could sue and recover damages. Thus a patient had the right
) be informed about the nature and implications of all proposed
ocedures. The patient had to be told of the material risks,
mplications and side-effects. Without such information the patient
as considered to be incapable of giving the consent that was
ecessary to authorise the medical procedure in the first place.
efenders of this principle asserted that it was less paternalistic
nd more respectful of the individual bodily and spiritual integrity
of the patient. Moreover, it was more likely to promote the solution
of the constant complaints made concerning the lack of communication
etween the patient and the medical practitioner. Critics, on the
other hand, suggested that it resulted in defensive medicine:
oposited a fundamental lack of trust between the patient and the
doctor; confused patients unnecessarily with detail they did not
want or need to hear; and bombarded them with information which they
could not fully understand, possibly alarming them needlessly about
risks which were remote - all of this taking up a great deal of time

which could be better spent actually treating patients rather than talking to them. The critics pointed out that it is a myth to suggest that anyone can be "fully informed" about anything - at least in an absolute sense. Still less will it be possible to convey "fully" complex data about the detail of medical procedures. Something less than such perfection will usually be all that it is reasonable to expect and to require by law.

In Canada, something of a compromise was struck between the United States and English positions in an important decision in 1980.⁵ The Chief Justice of Canada, Chief Justice Laskin observed:

*"In my opinion, actions of battery in respect of surgical or other medical treatment should be confined to cases where surgery or treatment has been performed or given to which there has been no consent at all or where, emergency situations aside, surgery or treatment has been performed or given beyond that to which there was consent."*⁶

However, the House of Lords in England, with a notable dissent from Lord Scarman, declined to follow the United States and Canadian decisions. This was the state of the law when the issue came up for decision in my own Court, the Court of Appeal of New South Wales, in the Full Court of the Supreme Court of South Australia and eventually in the High Court of Australia where it was finally settled for Australian law.

In my own Court, as long ago as 1980, it was emphasised:

*"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."*⁷

This approach was followed in South Australia where the Supreme Court refused to surrender to the medical profession the setting of standards which, if reached, would determine the entitlement of the patient who had suffered harm. In a very important decision, Chief Justice King of South Australia explained why such an approach was not acceptable:⁸

"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 and 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."

Notwithstanding this holding there were still many supporters in Australia of the Bolam principle. They were in the medical profession but also in the legal profession too.⁹ There was therefore a great deal of interest when the case of *Rogers v Whittaker*¹⁰ came for consideration before the High Court of Australia and was determined in November 1992.

The facts were these. Mrs Whittaker developed an extremely rare condition in her left eye. She had been nearly blind in her right eye from an early age as a result of a penetrating injury. At the age of 47, after a routine eye check-up, she was referred to Dr Rogers for advice on possible surgery. He advised her that he could operate on her right eye to remove the scar tissue. He said that this would improve its appearance... It would also probably

restore significant sight to that eye as well as assisting to prevent the development of glaucoma.

Unfortunately, following the operation, Mrs Whittaker developed an inflammation in the treated eye. This triggered sympathetic ophthalmia in the left (good) eye which led to a total loss of sight in the left eye, thereby leaving her almost totally blind.

The evidence at trial was that the risk of sympathetic ophthalmia developing after such surgery was estimated at 1 in 14,000 cases. Naturally, Mrs Whittaker did not ask Dr Rogers specifically whether the good eye could be affected by such a condition. However, it was found that she had incessantly questioned him as to complications and was keenly interested to know the outcome of the procedures and highly concerned that unintended injury could befall her good eye during the operation. This insistence was to such an extent that an entry was made in the hospital notes to the effect that Mrs Whittaker was apprehensive that the wrong eye would be operated upon.

The trial judge in the Supreme Court of New South Wales (Justice Campbell) found that Mrs Whittaker had not been properly warned about the risk of sympathetic ophthalmia and that, had she been so warned, she would not have undergone the surgery to the right eye. The lack of warning had therefore caused her to suffer the losses complained of. She was awarded just over \$800,000 damages. An appeal to the New South Wales Court of Appeal was dismissed.¹¹ The High Court of Australia dismissed Dr Rogers' further appeal. The Court preferred the view propounded in the Australian cases to the English *Bolam* test. It preferred Lord Scarman's dissent to the majority position of the House of Lords in England. It accepted that medical practice was a "useful guide" as to what should be told to a patient. It allowed an exception for the

called "therapeutic privilege", in cases of possible harm to an usually nervous, disturbed or volatile patient. One judge (Justice Iron) was inclined to confine this privilege to cases of emergency an impaired ability to receive, understand or evaluate such information.

The High Court of Australia was not attracted, as such, to the American jurisprudence of "fully informed consent". Nevertheless, Australian judges said this:

"The law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; 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 a particular patient, if warned of the risk, would be likely to attach significance to it."

Of course, some would say that it was ridiculous to suggest that a patient should be warned of a risk as remote as 1 in 14,000. Others would say that the case was special, turning upon the very clear evidence of the insistence by Mrs Whittaker of her concern about her good eye and her anxiety that it should not be harmed. Still others might say that it was difficult to overcome an intense sympathy for a woman who had merely gone to have her glasses checked and had ended up almost totally blind.

Medical practitioners tend to see malpractice cases as involving a moral blight or stigma upon the practitioner concerned. From the point of view of the patient (and most lawyers) however, the issue is usually much more basic. It is whether a person who has suffered in some way as a result of medical or hospital procedures will be cast upon the genteel poverty of the social security system or be entitled to recover compensatory damages from the medical practitioner's insurance. To gain insurance the practitioner must

ay premiums. These premiums become part of the costs of medical practice. In this way, all patients bear the cost of, and contribute to, the fund from which are paid damages when things go wrong.

In Queen Victoria's day an elderly Scottish judge observed of a case before him 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."*¹²

Times have changed. The reasons for the changes are easy enough to see. They include the general advance of education of the population at large and thus of patients; the decline of the awe of professionals and indeed of all in authority; the termination of unquestioning acceptance of professional judgment; the widespread public discussion of matters concerning health, including in the electronic media; and the growing recognition in medical practice of the importance of receiving a full input from the patient so that the whole person is treated, not simply a body part.

We must see the moves towards the insistence of the law upon the provision of greater information to patients in the context of the wider social developments which affect society and the law. All professions, including the judges, are now more accountable. The bureaucracy is now obliged by law to provide answers to the Ombudsman and to account for things formerly held secret. Freedom of Information legislation has been enacted in every jurisdiction of Australia. The sun has set not only on the British Empire but upon the world in which "Nanny", Sir Humphrey and others put in authority over us, always know best. In this context, if I ask have we gone too far by the decision in *Rogers v Whittaker*, the answer which I would suggest to you is that we have not. Perhaps it is time for the

English courts, which have given so much to the jurisprudence of the common law world, to receive in return the opinions of their rebellious progeny - and to reconsider the Bolam test. The difference between the standards expected in England and in the other countries is not large. But it is significant. And at the heart of the difference is an attitude to the fundamental rights of the particular patient. Those rights should take primacy both in legal formulae and in medical practice.

FOOTNOTES

- * President of the New South Wales Court of Appeal. Chairman of the Executive Committee of the International Commission of Jurists. Formerly Commissioner of the World Health Organisation Global Commission on AIDS. This paper is based on the Queen Victoria Hospital Oration, delivered by the author in Adelaide, South Australia, on 21 May 1993.
1. *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 (QBD).
 2. *Sidaway v Governors of Bethlem Hospital* [1985] AC 871 (HL), 876.
 3. *Bolam*, above n 1 at 586 (QBD).
 4. *Schloendorff v Society of New York Hospital* 211 NY 125; 105 NE 92, 93 (1914) (NYCA). See also *Canterbury v Spence* 464 F 2d (1972) (USCA).
 5. *Reibl v Hughes* (1980) 114 DLR (3d) 1 (SCC).
 6. *Ibid*, 7.
 7. *Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR

- 542 (CA), 562.
8. *F v R* (1983) 33 SASR 189 (SAFC) 194. See also Victorian Law Reform Commission, Report No 24, *Informed Decisions About Medical Procedures*, Melbourne, 1989, 7.
 9. See D I Cassidy, "Malpractice: Medical Negligence in Australia" (1992) 66 ALJ 67.
 10. (1992) 67 ALJR 47 (HC).
 11. (1991) 23 NSWLR 600 (CA).
 12. *Farquhar v Murray* (1901) 3 F 859, 862 cited by Lord Kilbrandon in Foreword in D Giesen, *International Medical Malpractice Law*, Tübingen, 1988.