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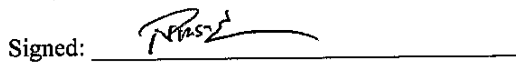
Signed: 

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The Law of Medical Negligence: Consent to Medical Treatment and Failure to Warn: Drafting a Model Bill

by

Nakil Navinesh Prasad

A thesis submitted in fulfillment of the
requirements for the degree of
Masters of Law

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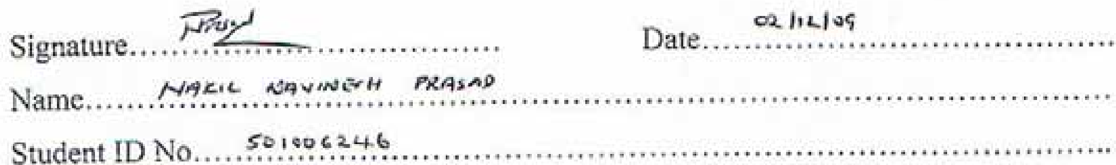
July 2009

DECLARATION

Statement by Author

I NAKIL NAVINESH PRASAD declare that this thesis is my own work, except for those sections explicitly acknowledged and that the main content of the thesis has not been previously submitted for a degree at this or any other university.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Statement by Supervisor

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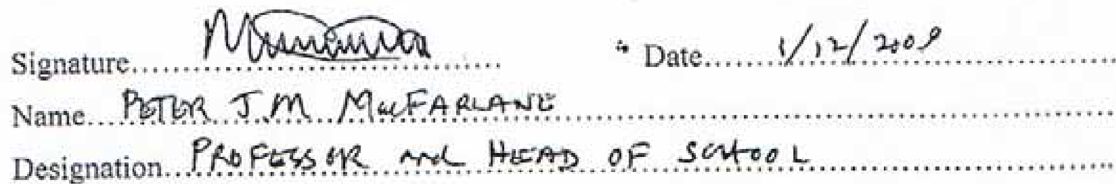
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I dedicate this thesis to my parents, Mr Narain Prasad and late Mrs Nirmala Prasad, my sister Nikita Prasad and my fiancée Nivinjiline Nainital Kumar.

ABSTRACT

This thesis focuses mainly upon the developments in the United Kingdom, New Zealand and Australian jurisdictions with respect to the area of law concerning medical negligence with emphasis on consent to medical treatment and failure to warn of risks and alternatives to treatment. Reference will be made to the Canadian and United States jurisdictions when contrasting the various jurisdictional approaches. This focus will inform my thesis regarding a model law on medical consent for Fiji.

The thesis is divided into 4 parts. Part I will trace the developments of the law concerning medical negligence. Part II will consider the statutory approach taken in some jurisdictions. Part III will focus on the various aspects of the law of consent to medical treatment and information disclosure and Part IV will involve the drafting of a model Bill adaptable to the Fiji jurisdiction.

In relation to consent to medical treatment, this thesis will consider: the age of consent, types of consent, elements of consent, exceptions to consent, consent pertaining to incompetent persons and minors, the scope of parental power, guardianship schemes and the inherent jurisdiction of the court. It will also make recommendations in terms of statutory provisions.

This thesis will also take into account the International Law that is applicable to this area of law. Furthermore, public opinion is analyzed through data collected from a research questionnaire handed out to the general public. The research questionnaire evaluates the understanding of the general public on the laws concerning consent to medical treatment and their views on the need for legislation in this particular area. The essence of codification pertaining to the law of consent to medical treatment is also discussed accordingly.

This thesis will conclude with a draft model of a Bill adaptable to Fiji jurisdiction. This Bill will include statutory provisions to deal with the area of law concerning consent to medical treatment thus providing a framework for better governance in the area of general medicine.

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INTRODUCTION

The Law of Medical Negligence is a very broad topic and this paper intends to explore the law concerning medical negligence with emphasis on consent to medical treatment and failure to warn of risks and alternatives to treatments.

Part I of this thesis will trace the developments in the law of medical negligence from 16th Century English Common Law and the causes of civil action arising in *trespass* and *negligence*. This part will also look at the elements of negligence and the Common Law approach towards 'standard of care' taking examples from the United Kingdom, Australia and Fiji jurisdictions. This part also explores the Bolam's 'standard of care' enunciated in the English case of *Bolam v Friern Hospital Committee* [1957] 2 All ER 118 and the contrary views outlined in the English cases of *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All ER 643 and *Bolitho v City and Hackney Health Authority* [1997] 4 All ER 771 and the rejection of the application of Bolam's 'standard of care' in the Australian case of *Rogers v Whitaker* [1992] 175 CLR 479. This part also looks into 'causation' with respect to the United Kingdom and Australian jurisdictions.

Part II of this thesis will explore the statutory approach to consent to medical treatment by tracing the developments through ethical considerations to statutory applications in the United Kingdom, Australia, New Zealand, Canada and Fiji jurisdictions. This Part will take examples from the States of New South Wales and Queensland in respect to the Australian jurisdiction and the province of Ontario in respect to the Canadian jurisdiction. This Part will also trace the developments through International Treaties and Conventions and will look at the *Convention on the Protection of Human Rights and the Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine*.

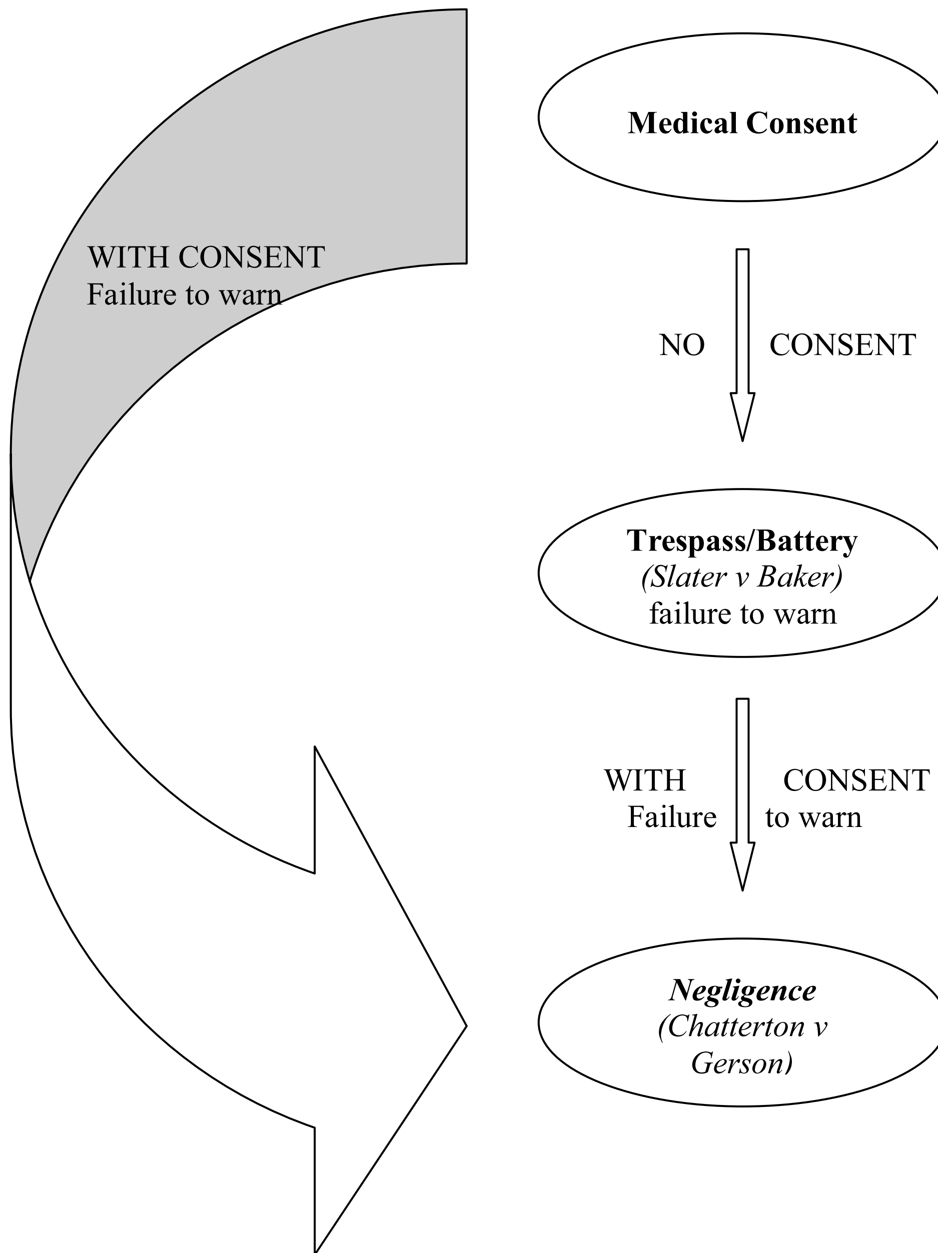
Part III of this thesis will explore the law concerning consent to medical treatment and information disclosure. This Part will also look at the contrary views regarding the extent of disclosure taking examples from the United Kingdom and Australian jurisdiction. This Part will analyze the contrary views in the States of New South Wales,

Queensland and South Australia in respect to the Australian jurisdiction. This Part also emphasizes the purpose of consent to medical treatment. This Part will also explore the statutory age requirements in the State of South Australia in respect to the Australian jurisdiction, in the New Zealand jurisdiction and in the Ontario province of the Canadian jurisdiction and in the Fiji jurisdiction. This Part will also look into how long the consent is valid for once given and reference will be made to the State of Queensland and the Australian Capital Territory in respect to the Australian jurisdiction. This Part will also outline the process for obtaining consent to medical treatment and reference will be made to the State of Queensland in respect to the Australian jurisdiction and the New Zealand, United Kingdom and Fiji jurisdictions. This Part will also make reference to the consent form available in the State of Queensland in respect to the Australian jurisdiction and look at the common law cases in the Canadian jurisdiction. Reference will also be made to the Fiji jurisdiction. This Part will also look into the elements of a valid consent with emphasis on express and implied consent. This Part will also explore the circumstances when the patient's consent is not required based upon the exceptions of doctrine of necessity, emergency, waiver by patient, therapeutic privilege and waiver by Statute. This Part also looks into how consent is vitiated and a patient's capacity to consent to medical treatment. Reference is also made to the incompetent persons, minors, and the scope of parental power, the guardianship schemes and the inherent jurisdiction of the court. This Part also explores consent in respect to specific invasive procedures such as abortion and blood transfusion.

Part IV of this thesis will formulate a model Medical Consent Bill. This Part will discuss the essence of codification pertaining to the law of consent to medical treatment. This Part will also analyze public opinion obtained through data collected from a research questionnaire handed out to the general public. The research questionnaire was intended to evaluate the understanding of the general public on the laws concerning consent to medical treatment and their views on the need for legislation in this particular area. This thesis will conclude with a draft model of a Bill adaptable to Fiji jurisdiction. This Bill includes statutory provisions dealing with the area of law concerning consent to medical treatment.

Part 1: Tracing the Developments in the Law of Medical Negligence

1.1 Background



The law concerning consent to medical treatment is fundamental to the practice of medicine. This law is still developing from its initial conception. A shift from "medical paternalism" to the "self determination" or "rights-based approach" is evident.

This development can be traced from 16th Century English Common Law and the causes of civil action arising in *trespass* and *negligence*. Other possible civil remedies applicable in this area are *breach of contract* and *breach of fiduciary duty*.

1.11 Trespass

The concept of medical consent was developed by the common law for the protection of individual patients in the English case of *Slater v Baker & Stapleton* (1767) 2 WILS KB 359.

The facts of the case are as follows:

> The patient visited the physicians with the view to have his leg cured 'which had been broken and set, and the callous of the fracture formed.'[1] 'Instead, and over the patient's objection, the physicians re-fractured, set, and braced the leg in what was evidently an experimental device.'[2]

Chief Justice Wilmot in a single judgment noted at 362:

> *It appears from the evidence of the surgeons that it was improper to disunite the callous without consent; this is the usage and law of surgeons: then it was ignorance and unskilfulness in that very particular, to do contrary to the rule of the profession, what no surgeon ought to have done; and indeed it is reasonable that a patient should be told what is about to be done to him, that he may take the courage and put himself in such a situation as to enable him to undergo operation. It was objected, this verdict and recovery cannot be pleaded in bar to an action of trespass vi & armis to be brought for the same damage; but we are clear of opinion it may be pleaded in bar.*

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[1] *Slater v Baker & Stapleton* (1767) 2 WILS KB 359.

[2] W John Thomas, 'Informed Consent, the Placebo effect and the revenge of Thomas Percival' (2001) 22 *Journal of Legal Medicine* 313 http://webspace.quinnipiac.edu/thomas/InformedConsentPlaceboEffectACLMversion2.pdf (Assessed 23 February 2008).

The landmark decision in *Slater v Baker & Stapleton* gave rise to the concept of medical consent. Initially, failure to warn of risks and alternatives to treatments was pleaded in *trespass*. The standard of skill applied was tested under the 'usage and law of surgeons'[3], whereby acts that were 'contrary to the rule of the profession, what no surgeon ought to have done'[4], amounted to an action in *trespass*.

Emphasis was placed on the medical fraternity to elaborate on the skillfulness in their profession and on acts that were within the rule of the profession with the courts to decide on the liability of damages. It was regarded as proper that the consent of the patient was obtained before any medical treatment or procedure was commenced.

1.12 Action in Trespass or Negligence

This use of *trespass* as an action where there had been a failure to warn the patient of the risks and alternatives to medical treatment was criticized in *Chatterton v Gerson* [1981] 1 All ER 257.

The facts of the case are as follows:[5]

> The patient experienced chronic pain in the region surrounding the hernia operation scar. The doctor treated this with a solution being injected near the spinal cord. A temporary relief was provided however the patient began to experience numbness and loss of muscle power. A second spinal injection was given to the patient. This second operation was unsuccessful and did not provide any relief at all. The patient's right leg became completely numb and she claimed that the physician had not given her an explanation of the operation and their implications so that she could make an informed decision whether to risk them.

[3] Above n 1, 362.
[4] Above n 1, 362.
[5] *Chatterton v Gerson* [1981] 1 All ER 257.

Justice Bristow in a single judgment noted at 265:

> *When the claim is based on negligence the plaintiff must prove not only the breach of duty to inform but had that duty not been broken she would not have chosen to have the operation.*
>
> *When the claim is based on trespass to the person, once it is shown that the consent is unreal, then what the plaintiff would have decided if she had given the information which would have prevented vitiation of the reality of her consent is irrelevant.*
>
> *In my judgment, once the patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real, and the cause of the action on which to base a claim for failure to go into risks and implications is negligence, not trespass…But in my judgment it would be very much against the interests of justice if actions which are really based on a failure by the doctor to perform his duty adequately to inform were pleaded in trespass*
>
> *I should add that getting the patient to sign a pro forma expressing consent to undergo the operation 'the effect and nature of which have been explained to me', as was done here in each case, should be a valuable reminder to everyone of the need for explanation and consent. But it would be no defence to an action based on trespass to the person if no explanation had in fact been given. The consent would have been expressed in form only, not in reality.*

Justice Bristow pointed out that an action in *trespass* arises in the absence of consent, whereas an action in *negligence* arises if a real consent is given. According to Justice Bristow, a consent amounts to real consent if the patient gives the consent after analyzing the information explained to him/her by the doctor in relation to the nature and effect of the proposed treatment or procedure. However, an action in negligence will

only succeed, provided it is established that the doctor failed to inform about the risks and alternatives to treatments and the said disclosure if known would have given the patient the choice to decide otherwise about the said treatment.

Chatterton v Gerson made reference to the Canadian case of *Reibl v Hughes* (1980) 114 DLR (3d) 1 which in turn looked at the United States cases of *Schloendorff v Society of New York Hospital* (1914) 211 NY 125 and *Salgo v Leland Stanford Jr University Board of Trustees* 317 p.2d 170 (California District Court of Appeal 1957).

In *Reibl v Hughes* Chief Justice Laskin in a majority judgment noted at 10-11:

> *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.*
>
> *Unless there has been misrepresentation or fraud to secure consent to the treatment, a failure to disclose the attendant risks, however serious, should go to negligence rather than to battery.*

The early cases were pleaded in *trespass* and the principles of these to some extent were referred to in distinguishing *negligence* cases. These principles of *trespass* are outlined in the United States cases of *Schloendorff v Society of New York Hospital* and *Salgo v Leland Stanford Jr University Board of Trustees*.

In *Schloendorff v Society of New York Hospital* Justice Cardozo in a majority judgment noted at 129:

> *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.*"

In *Salgo v Leland Stanford Jr University Board of Trustees* Justice Bray in a majority judgment noted at 181:

> *A physician violates his duty to his patient and subjects himself to liability if he withholds any facts, which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce the patient's consent.*

The English, United States and the Canadian cases affirm the position that where there is no consent the action is pleaded in *trespass*. If consent is provided, however, there is failure to disclose on the part of the doctor to warn of the risks and alternatives to treatments then the action is pleaded in *negligence*.

The position in Australia as far as consent is concerned is that matters are pleaded in *trespass*, in circumstances whereby no consent was provided. If consent is provided but there is an issue on a doctors duty of disclosure or failure to warn of risks and alternatives to treatment then the action is pleaded in *negligence*. This view is outlined in the case of *Rogers v Whitaker* [1992] 175 CLR 479.

The facts of the case are as follows:[6]

> The patient was experiencing blindness in her right eye and visited the physician for treatment. The physician conducted an operation in the right eye, which subsequently led to blindness in her left eye. As a result of the operation, the patient was visually impaired and claimed that the physician failed to warn her of the risks involved in the treatment.

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[6] R*ogers v Whitaker* [1992] 175 CLR 479.

Mason CJ, Brennan, Dawson, Toohey and McHugh JJ in a joint judgment noted at 490:

> *In this context, nothing is to be gained by reiterating the expressions used in American authorities, such as 'the patient's right of self-determination' or even the oft-used and somewhat amorphous phrase 'informed consent'. The right of self-determination is an expression, which is, perhaps, suitable to 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. Likewise, the phrase 'informed consent' is apt to mislead as it suggests a test of the validity of a patient's consent. Moreover, consent is relevant to actions framed in trespass, not in negligence. Anglo-Australian law has rightly taken the view that an allegation that the risks inherent in a medical procedure have not been disclosed to the patient 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. In Reibl v Hughes the Supreme Court of Canada was cautious in its use of the term 'informed consent'.*

The emphasis here is on failure to warn of risks and alternatives to treatment. Historically this action was based on failure to get informed consent. In brief, informed consent is a due process analogues to real consent[7], however, the earlier requires full disclosure of information by the Physician and focuses 'on what the patient would want to know, including about adverse effects, risks of failure, alternative choices and how that individual patient could be affected by the treatment or of its lack.'[8]

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[7] A consent amounts to real consent if the patient gives the consent after analyzing the information explained to him/her by the doctor in relation to the nature and effect of the proposed treatment or procedure.

[8] Dr SMA Babar, 'True Consent, informed consent and the English law' (2004) http://www.geradts.com/anil/ij/vol_005_no_002/papers/paper002.html (Assessed 4 December 2008).

Nearly twelve years before *Rogers v Whitaker* 'the issues [on failure to warn] were canvassed… in [an] interlocutory judgment given in the absence of the jury on 26 June 1980'[9] in *Hart v Heron and Chelmsford Private Hospital*[10].

Justice Fisher noted at 7:

> *I have been furnished with a number of decisions mostly from Canada and the United States that seem to say that if consent is not 'full', 'real', 'genuine', or 'informed' or similar then seemingly as a matter of law there can be no consent. This is particularly so in relation to informed consent, which predicates the presentation of substantial information by the doctor to the patient ... But with due respect to the doctrinal argument consent is consent .... To press further is really to push the matter pleaded in battery to an issue that should be debated within the concept of negligence ... I would observe that the appropriate place for [informed consent] is in the context of a count in negligence based upon alleged failures to warn or inform*

The Australian courts have favored the proposition that failure to warn must be pleaded as an action in *negligence* as opposed to an action in *trespass*. The move is fundamental as an action in *negligence* requires proof of breach of duty but an action in *trespass* does not.[11]

Stephen F Smith in an article on *Some Recent Cases on Informed Consent*[12] noted at 414:

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[9] Stephen F Smith, 'Some Recent Cases on Informed Consent' 413 *The Adelaide Law Review* 425 http://digital.library.adelaide.edu.au/dspace/bitstream/2440/43905/1/alr_V9n3_1984_SmiSom_Com.pdf (Assessed 22 December 2008).

[10] *Hart v Heron and Chelmsford Private Hospital* (unreported jury trial before Fisher J Supreme Court of NSW No 12781 of 1979. Judgment delivered 11 July 1980) cited in Stephen F Smith, 'Some Recent Cases on Informed Consent' 413 *The Adelaide Law Review* 425 http://digital.library.adelaide.edu.au/dspace/bitstream/2440/43905/1/alr_V9n3_1984_SmiSom_Com.pdf (Assessed 22 December 2008).

[11] Trespass is actionable upon prove of the unlawful interference of the person.

[12] Stephen F Smith, Above n 9.

How then does one set about introducing the tort of battery into medical cases? The answer is by the American doctrine of 'informed consent'. This doctrine postulates that if a patient is not apprised of the risks, alternatives and consequences of a medical procedure, particularly surgery, any 'consent' given to it is in form only and ineffective in substance. Thus, the doctor will be open to suit in battery wherein the plaintiff can claim that bodily integrity has been invaded intentionally by the doctor who will be likely to lose the action unless it can be established that before the procedure in question an effective consent was obtained. Almost always negligence will be pleaded as an additional count, specifically a breach of duty by the doctor in failing to obtain an effective consent or failing to warn, advise or inform the patient adequately before the procedure was undertaken. The negligence aspect holds that the doctor has a duty founded on the tort of negligence, to warn, advise or inform the patient about what is proposed. As a consequence, apart from the result of failure to inform as an issue in trespass, the same failure to inform might also be a breach of duty, opening the way for a negligence action….Perhaps 'informed consent' should be applied exclusively to the battery issue and a term such as 'duty to warn and advise' used for negligence aspects.

Stephen F Smith's view was that 'so while there probably is no doctrine of informed consent as grounding an action in *battery,* failure to inform patients adequately can lead to an action in *negligence…*'[13]

Vivienne Harpwood in her book *Modern Tort Law*[14] noted at 274:

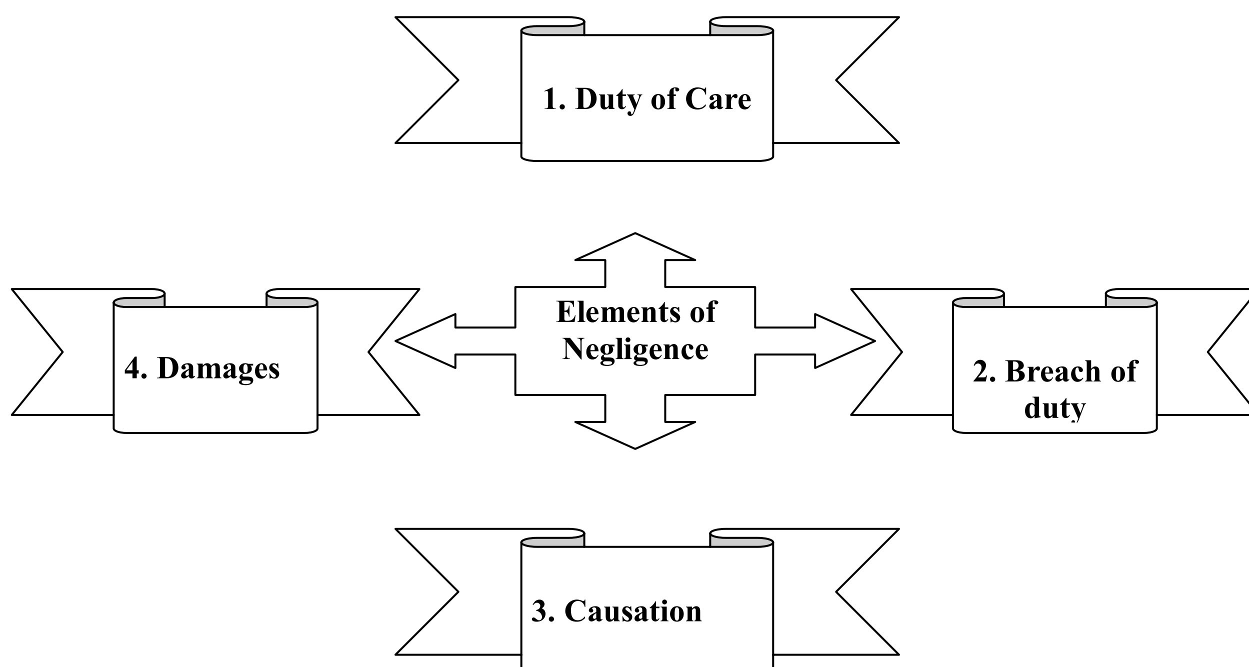
The claimant must establish whether negligence or trespass is the correct cause of action, and this could be important for several reasons. First, trespass is actionable without proof of damage, whereas in negligence, damage must

[13] Stephen F Smith, Above n 9, 425.
[14] Vivienne Harpwood, *Modern Tort Law* (5th ed 2003) http://books.google.com.fj/books?id=qHC9IRws8pwC&pg=PA273&lpg=PA273&dq=Move+from+trespass+to+action+in+Negligence&source=web&ots=f2Ev4iqsPz&sig=uoLmcu1FLJvjiP2s0fSH1nwk_A8&hl=en&sa=X&oi=book_result&resnum=3&ct=result#PPA273,M1 (Assessed 22 December 2008).

always be proved. Second, it is easier to prove causation in trespass than negligence. Third, there is greater flexibility in the limitation period in medical negligence claims than in claims for trespass (Stubbings v Webb [1992] QB 197

Vivienne Harpwood raises an important issue on what cause of action is to be pleaded.[15] However it is evident in some jurisdiction that usually medical negligence matters initiated in court are pleaded in both *trespass* and *negligence* leaving it up to the court's discretion to make their determination on the probable cause of action.

1.13 Elements of Negligence



'The law [on failure to warn] in the [United Kingdom] has its roots firmly set in the field of medical negligence.'[16] 'The reason for this is that the question never appears in court until something goes wrong and a doctor is sued for negligence on the grounds that he failed to warn the patient of risks or failed to supply other relevant information.'[17]

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[15] Above n 14.
[16] Ian Pinder-Packard, 'The Law as it Stands' in Ian Pinder-Packard (eds), *The Law, Practice and Morals of Informed Consent* http://website.lineone.net/~drones/DISS/LAW.HTM (Assessed 1 May 2008).
[17] Above n 16.

For liability to be established under negligence, the above four elements must be proven by the plaintiff on the balance of probabilities, namely 'that the defendant owed a duty of care; that the defendant did not meet the required standard of care; that the breach of the duty of care caused loss or damage to the plaintiff; and that the loss or damage was reasonably foreseeable'[18].

1.131 Duty of Care

In the medical context, a doctor-patient relationship needs to be established in order to prove that the doctor owed a duty of care to the patient. This duty arises out of the relationship of "proximity" and was enunciated into a single general principle in the English case of *Anns v Merton London Borough Council* (1978) AC 728.

Lord Wilberforce in a majority judgment noted at 751-752:

> *Through the trilogy of cases in this House - Donoghue v Stevenson, Hedley Byrne & Co. Ltd. v Heller & Partners Ltd. (1964) AC 465, and Dorset Yacht Co. Ltd. v Home Office, the position has now been reached that in order to establish that a duty of care arises in a particular situation, it is not necessary to bring the facts of that situation within those of previous situations in which a duty of care has been held to exist. Rather the question has to be approached in two stages. First one has to ask whether, as between the alleged wrongdoer and the person who has suffered damage there is a sufficient relationship of proximity or neighbourhood such that, in the reasonable contemplation of the former, carelessness on his part may be likely to cause damage to the latter - in which case a prima facie duty of care arises. Secondly, if the first question is answered affirmatively, it is necessary to consider whether there are any considerations which ought to negative, or to reduce or limit the scope of the duty or the class of person to whom it is owed…*

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[18] Victoria Law Reform Committee, *Legal Liability of Health Service Providers* (1997) [2.6] http://www.parliament.vic.gov.au/lawreform/inquiries/Liability%20of%20Health%20Service%20Providers/final%20report.pdf (Assessed 1 May 2008)

This duty of care later evolved into the "tripartite test" as espoused in *Caparo Industries plc v Dickman* [1990] 1 All ER 568 to include '(1) foreseeability of loss, (2) proximity and (3) fairness, justice and reasonableness'[19]. However, in the medical context, 'this duty arises out of the [doctor-patient] relationship'[20].

Richard A Black in an article on *The Doctors Duty to Patient*[21] noted at 1-2:

> *The first element essential to any tort litigation is duty. In a malpractice action it must be shown that the doctor owed a duty to that patient. Critical to the showing of duty owed is the issue of whether a doctor-patient relationship has been established.*
>
> *The doctor-patient relationship may arise with far less formality that the physician realizes. Written contracts are not needed, documentation is not necessary, the patient need not even visit the doctor's office. Surprisingly enough, the patient may not even need to have talked directly with the doctor.*
>
> *The existence of the doctor-patient relationship may not depend upon the doctor's intent. The relationship comes into existence when the impression is created in the mind of a reasonable patient.*

Richard A Black in any event concludes that the duty of care arises on the basis of a doctor-patient relationship. The relationship need not be contractual or direct as long as

[19] 'This tripartite test for the existence of a duty of care derives from a series of appellant decisions in *Peabody Donation Fund v Sir Lindsay Parkinson & Co. Ltd* [1985] AC 210; *Yuen kun-yeu v AG of Hong Kong* [1988] AC 175; *Smith v Bush* [1990] 1 AC 831 at 865, per Lord Griffiths; *Caparo Industries plc v Dickman* [1990] 2 AC 605 [and was applied in *Stovin v Wise* (Norfolk County Council, third party) [1996] 3 All ER 801]. These cases (and others) represented a retreat from what was perceived to be the unacceptable implications of a wide formulation of the test for the duty of care by Lord Wilberforce in *Anns v Merton London Borough Council* [1978] AC 728 at 751-2, a process that culminated in the overruling of that decision by the House of Lords in *Murphy v Brentwood District Council* [1991] 1 AC 398. Although these decisions deal with the duty of care in general terms, they are virtually exclusively concerned with liability for pure economic loss and have little relevance in the context of medical malpractice litigation.' (see Michael A Jones, *Medical Negligence* (4th ed, 2008) at 85)

[20] Charles J Lewis, *Medical Negligence A Practical Guide* (2nd ed, 1992) at 179.

[21] Richard A Black, 'The Doctors Duty to a Patient' http://www.christianchiropractors.org/black.htm (Assessed 1 May 2008).

it is evident at that point in time that there was reasonable reliance by the patient that he/she was under the care of the doctor.[22]

The common law rule of reasonable reliance was emphasized in the English case of *Hedley Byrne & Co. Ltd. v Heller & Partners Ltd* [1963] 2 All ER 575.

Lord Hodson in a majority judgment noted at 601:

> *…where a person is so placed that others could reasonably rely upon his judgment or his skill or upon his ability to make careful inquiry, and a person takes it upon himself to give information or advice to, or allows his information or advice to be passed on to, another person who, as he knows or should know, will place reliance upon it, then a duty of care will arise.*

Subsequent to *Hedley Byrne & Co. Ltd. v Heller & Partners Ltd* almost 22 years later, emphasis was placed on doctor's duty of care in the English case of *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All ER 643.

Lord Scarman in a dissenting judgment noted at 652:

> *If it be recognized that a doctor's duty of care extends not only to the health and well-being of his patient but also to a proper respect for his patient's rights, the duty to warn can be seen to be part of the doctor's duty of care.*[23]

The Australian jurisdiction has recognized that diagnosis and treatment on the one hand and provision of information or advice, on the other hand, are part and parcel of the doctor's duty of care, which arises in the doctor-patient relationship.[24]

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[22] Above n 21.

[23] This dissenting view of Lord Scarman 'that the duty to warn can be seen as part of the doctor's duty of care' was approved in the Australian case of R*ogers v Whitaker* [1992] 175 CLR 479 and in the English case of *Chester v Afshar* [2004] 4 All ER 587.

[24] Above n 6, 493.

In *Gover v South Australia and Perriam* (1985) 39 SASR 543 Justice Cox noted at 551:

> *The medical man's duty… extends to the whole of the professional relationship, including examination, diagnosis, treatment whether medical or surgical, and the need in an appropriate case to provide information to the patient*

In *Rogers v Whitaker* Justice Gaudron in a majority judgment noted at 493:

> *Diagnosis and treatment are but particular duties which arise in the doctor-patient relationship. That relationship also gives rise to a duty to provide information and advice. That duty takes its precise content, in terms of the nature and detail of the information to be provided, from the needs, concerns and circumstances of the patient.*

The English and the Australian jurisdictions have taken the approach 'that doctor's general duty to act reasonably includes a duty to provide adequate information'[25].

Contrary views have been expressed by the American jurisdictions whereby a 'doctor's duty to take reasonable care in the provision of information is a separate or different duty from that in relation to diagnosis and treatment'[26]. The American jurisdiction focuses on informed consent and the right to self determination which is grounded in an action in *trespass*.[27] However, the American jurisdiction have given recognition to the principle that a doctor owes a duty of care to his or her patient and this duty arises out of the doctor-patient relationship.

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[25] NSW Law Reform Commission, *Informed decisions about medical procedures*, Report No 62 (1989) http://www.lawlink.nsw.gov.au/lrc.nsf/pages/R62APPENDIX1 (Assessed 21 April 2008).
[26] Above n 25.
[27] 'In deciding whether a doctor has given a patient adequate information, some American courts have focused not simply on whether the doctor acted reasonably but, rather, on the patient's right to self-determination - to make his or her own medical decisions and to be provided with sufficient information to give an "informed consent". There is legislation in about half of the American States on 'informed consent'. For the most part, it is intended to protect doctors who give reasonable information to patients, rather than to require that patients be given detailed information. What follows is based on case law in those States that do not have such legislation.' (see Above n 25).

From the analysis of the above cases and articles, it is evident that the English and the Australian jurisdictions have recognized that a doctor owes a duty of care to his/her patient. This duty arises out of the doctor-patient relationship and extends to diagnosis, treatment and provision of information or advice. Furthermore the doctor-patient relationship does not have to be contractual or direct. However there must be reasonable reliance by the patient to indicate that he/she was under the care of the doctor.

1.132 Standard of Care

'While the duty of care is usually easily established in cases of negligence where there is doctor-patient relationship, the standard of care owed and the content of the duty owed has been a more complicated question at law.'[28]

This 'standard of care which the law demands of a person in a negligence case has been established to be the standard of "reasonable care".'[29] However, there has been much debate on whether the scope of reasonable care is something for the medical man to deliberate upon or is it within the courts discretion to make that determination.

1.1321 Bolam Standard of Care

The *locus classicus* or leading case for the test applied to ascertain the standard of care applicable at common law was established in the English case of *Bolam v Friern Hospital Committee* [1957] 2 All ER 118 (known as the Bolam Principle).

The facts of the case are as follows:[30]

> The patient was suffering from depression. He visited Frien Hospital and was seen by the consultant psychiatrist Dr J De Bastarrechea. The doctor advised him

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[28] Above n 18, [2.8].

[29] Puteri Nemie Jahn Kassim, 'Does the Bolam Principle still reigns in medical negligence cases in Malaysia' *The International Medical Journal* http://www.e-imj.com/Vol2-No1/Vol2-No1-H3.htm (Assessed 21 April 2008).

[30] *Bolam v Friern Hospital Committee* [1957] 2 All ER 118 at 119.

to undergo electro-convulsive therapy (ECT), but he failed to warn him of the risks inherent in the treatment. The patient signed a form consenting to the treatment. Furthermore the doctor failed to give him any relaxant drugs before commencing the treatment. 'In the course of this treatment the [patient] sustained severe physical injuries consisting in the dislocation of both hip joints with fractures of the pelvis on each side.'[31] The patient amongst other things claimed that the doctor failed to warn him of the risks involved in the treatment.

Justice McNair in a single judgment noted at 121:

In the ordinary case which does not involve any special skill, negligence in law means this: some failure to do some act which a reasonable man in the circumstances would do, or doing some act which a reasonable man in the circumstances would not do; and if that failure or doing of that act results in injury, then there is a cause of action.

But where you get a situation which involves the use of some special skill or competence, then…The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent medical men exercising that particular art.

And at 122:

A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.

[31] Above n 30.

> *Finally, bear this in mind, that you are now considering whether it was negligent for certain action to be taken in August, 1954, not in February, 1957; and in one of the well-known cases on this topic it has been said you must not look through 1957 spectacles at what happened in 1954.*

The Bolam principle emphasizes that the standard of care applicable in the case of medical negligence is that of an ordinary skilled medical man 'in accordance with the standards of reasonably competent medical men at the time'[32].

'The Bolam principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice.'[33] 'In short, the law imposes the duty of care but the standard of care is a matter of medical judgment.'[34]

It is submitted that the Bolam test fails to take into account the interests of the patient. The action of a doctor falls within the standard of reasonable care if a "responsible body of medical men" makes that determination. The notion of handing over to the medical profession to make determination on the standard of reasonable care and whether there is a breach of duty, arising due to falling short of this standard, raises issues on the quality and fairness of the expert opinion. This test extends the role of the medical profession to being the "gatekeeper" or "custodian" of their actions and provides a subjective approach to the determination on the standard of care. This determination by the medical profession is not questionable at law and therefore fails to do justice to the patient. The method of treatment carried out by the doctor might be used by many doctors in the profession but that does not mean that the method falls within the standard of reasonable care. The emphasis is on reasonableness and therefore it is best to leave that determination to the court. However, the medical profession can provide their expert views on the standard of care, but it is for the courts to make a determination on the standard of reasonable care that is applicable. The judges are the "custodian" of the

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[32] Above n 30, 121.
[33] *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All ER 643 at 649 (Lord Scarman dissenting)
[34] Above n 33.

law and it is best that the court makes the determination on the standard of reasonable care and whether there is a breach of duty as a result of falling short of this standard.

'The Bolam Principle has been accepted by [the] house as applicable to diagnosis (*Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635) and treatment (*Whitehouse v Jordan* [1981] 1 All ER 267).'[35] 'It is also recognized in *Scots* law as applicable to diagnosis and treatment; indeed McNair J in the *Bolam* case cited a Scottish decision to that effect [in] *Hunter v Hanley* (1955) SLT 213.'[36]

In *Hunter v Hanley* Lord President Clyde noted at 217:

> *In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion, and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved guilty of such failure as no doctor of ordinary skill would be guilty of it acting with ordinary care.*

Accordingly, 'a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view'[37]. 'It is immaterial that there exists another body of opinion that would not have adopted the approach taken by the doctor in question.'[38] 'As long as there exists a "responsible body of medical opinion" that approves of the actions of the doctor, then the doctor escapes liability.'[39]

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[35] Above n 33.
[36] Above n 33.
[37] Above n 30, 122.
[38] Puteri Nemie Jahn Kassim, Ahmad Ibrahim, 'Medical Negligence Litigation in Malaysia: Current Trend and Proposals for Reform' at [4.1] http://mdm.org.my/downloads/dr_puteri_nemie.pdf (Assessed 21 April 2008)
[39] Above n 38, [4.1]

The Bolam principle pertaining to the standard of care was accepted by the majority in *Sidaway v Bethlem Royal Hospital Governors*.

The facts of the case are as follows:[40]

> The patient was suffering from constant pain in her neck and shoulders and was advised to undergo an operation on her spinal column. 'The surgeon warned [Mrs Sidaway] of the possibility of disturbing a nerve root and the possible consequences of doing so but did not mention the possibility of damage to the spinal cord even though he would be operating within three millimeters of it.'[41] '[Mrs Sidaway] consented to the operation, which was carried out by the surgeon with due care and skill.'[42] 'However, in the course of the operation [Mrs Sidaway] suffered injury to her spinal cord which resulted in her being severely disabled.'[43] Mrs Sidaway claimed that the surgeon failed to warn her of all possible risks inherent in the operation.

Lord Diplock in a majority judgment noted at 659:

> *To decide what risks the existence of which a patient should be voluntarily warned and the terms in which such warning, if any, should be given, having regard to the effect that the warning may have, is much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care to the individual patient, and expert medical evidence on this matter should be treated in just the same way. The Bolam test should be applied.*

The recent decision in *Morianna Loretta Telles v South West Strategic Health Authority* [2008] EWHC 292 (QB) affirms the position that the Bolam principle is still applicable in its original form in the English courts.

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[40] Above n 33, 643
[41] Above n 33, 643
[42] Above n 30, 643
[43] Above n 30, 643

1.1322 Contrary views comparing Bolam Standard of Care

'The existence of the Bolam principle had clearly made it difficult for plaintiff to prove that the doctor had positively breached a standard of care owed in the circumstances.'[44] 'This is due to the fact that the Bolam principle has been routinely interpreted by the courts as laying down a principle whereby a court cannot find a defendant negligent as long as there is a common practice or custom that supports the defendant's actions.'[45] 'The "custom test" has been purely descriptive, based on what is customarily done by the medical practitioners, rather than what ought to be done by the medical practitioners.'[46]

(i) English Courts

The Bolam principle in relation to the provision of information, advice and warning was adopted by the majority of the House of Lords in *Sidaway v Bethlem Royal Hospital Governors*. However Lord Scarman, in his judgment provided a dissenting view, refusing to apply the Bolam principle to cases involving the provision of advice or information.

Lord Scarman in a dissenting judgment noted at 645:

> *In my view the question whether or not the omission to warn constitutes a breach of the doctor's duty of care towards his patient is to be determined not exclusively by reference to the current state of responsible and competent professional opinion and practice at the time, though both are, of course, relevant considerations, but by the court's view whether the doctor in advising his patient gave the consideration which the law requires him to give to the right of the patient to make up her own mind in the light of the*

[44] Above n 38, [4.1].
[45] Above n 38, [4.1].
[46] Above n 38, [4.1].

relevant information whether or not she will accept the treatment which he proposes.

In *Maynard v West Midlands Regional Health Authority* Lord Scarman in a majority judgment noted at 639:

I have to say that a judge's 'preference' for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose opinions, truthfully expressed, honestly held, were not preferred. If this was the real reason for the judge's finding, he erred in law even though elsewhere in his judgment he stated the law correctly. For in the realm of diagnosis and treatment negligence is not established by preferring one respectable *body of professional opinion to another. Failure to exercise the ordinary skill of a doctor (in the appropriate specialty, if he be a specialist) is necessary.*

In *Hucks v Cole* [1993] 4 Med LR 393, the English Courts took the approach of subjecting the expert opinion of doctors to judicial scrutiny whereby the courts set the standard at law rather than leaving the determination of liability unto the medical profession.[47] 'The judgment of Lord Justice Sachs was very influential in bringing about the change in attitude by the English judiciary of delegating the determination of doctor's liability to the medical profession.'[48] 'The judges in this case adopted a pragmatic approach to this issue and held that it was appropriate for the judge to reject medical expert evidence if it does not really stand up to analysis.'[49]

It was not until *Bolitho v City and Hackney Health Authority* [1997] 4 All ER 771 when Lord Browne-Wilkinson recognized the decision in *Hucks v Coles.* In his judgment, Lord Browne-Wilkinson held that 'the court is not bound to hold that a

[47] Above n 38, [4.4].
[48] Above n 38, [4.4].
[49] Above n 38, [4.4].

defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment and diagnosis accorded with sound medical practice'[50].

The facts of the case are as follows:[51]

> The patient, a two-year-old boy, P, with past medical history for treatment of croup was re-admitted to City and Hackney Health Authority. He suffered two short episodes at 12:40 pm and 2:00 pm and had difficulty breathing. Dr H was called in the first instance and she delegated Dr R to attend in the second instance but neither attended P. At about 2:30 pm P suffered total respiratory failure and a cardiac arrest, resulting in severe brain damage leading to his death.

Lord Browne-Wilkinson in a majority judgment noted at 779:

> *These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare*

[50] *Bolitho v City and Hackney Health Authority* [1997] 4 All ER 771 at 778.
[51] Above n 50, 771

case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.

I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment, which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the bench mark by reference to which the defendant's conduct falls to be assessed… I turn to consider whether this is one of those rare cases. Like the Court of Appeal, in my judgment it plainly is not.

'Thus, the House of Lords in the case of *Bolitho v. City and Hackney Heath Authority* re-inter the Bolam test and held that Bolam itself did leave room for further judicial examination as far as medical practice and medical evidence is concerned.'[52] 'Hence the decision of the court in the Bolam case was not conclusive of the standard of care expected of a doctor.'[53] 'It will turn on the facts and circumstances of each case and the underlying question is whether the professional opinion is capable of withstanding logical analysis, and if not, the judge is entitled to hold that the body of opinion is not reasonable or responsible.'[54]

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[52] Clement Chigho, 'Negligence And Medical Liability Part: 1' (2006) *The Bahama Journal* http://www.jonesbahamas.com/?c=135&a=9748 (Assessed 1 April 2008).
[53] Above n 52.
[54] Above n 52.

According to *Bolitho v. City and Hackney Heath Authority*, the 'court will have the last say in considering expert medical evidence in making a determination as to whether a breach of duty has occurred'[55].

(ii) Australian Courts

The Australian jurisdictions have rejected the application of the Bolam standard of care as applied to the provision of information or advice and to diagnosis and treatment. In the first instant, the Bolam principle in relation to the provision of information or advice was rejected in *Rogers v Whitaker*. Subsequently the Bolam principle was rejected in its application to diagnosis and treatment in *Naxakis v Western General Hospital* (1999) 73 ALJR 782. The common law position in Australia is that the provision of expert medical opinion must be subjected to judicial scrutiny and it is the court that will have the final say on standard of reasonable care required of doctor's at law. This test was stated in *F v R* (1982) 33 SASR 189.

Chief Justice King noted at 194:

> *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.*
>
> And at 192-193:
>
> *That the amount of information or advice which a careful and responsible doctor would disclose depended upon a complex of factors: 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.*

[55] Above n 52.

The test emphasizes that it is for the court to decide whether a doctor conforms to the standard of reasonable care demanded at law.[56] This view taken by Chief Justice King is similar in approach to the view taken two years later by Lord Scarman in *Sidaway v Bethlem Royal Hospital Governors*.

This view was adopted in *Rogers v Whitaker* 'where it was accepted that the question of how much information to be imparted by a doctor cannot be determined by "any profession or group in the community"[57] but it should be determined upon consideration of complex factors, namely, "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"[58].'[59]

Mason CJ, Brennan J, Dawson J, Toohey J, McHugh J in a joint judgment noted at 486-487:

> *One consequence of the application of the Bolam principle to cases involving the provision of advice or information is that, even if a patient asks a direct question about the possible risks or complications, the making of that inquiry would logically be of little or no significance; medical opinion determines whether the risk should or should not be disclosed and the express desire of a particular patient for information or advice does not alter that opinion or the legal significance of that opinion.*
>
> *In Australia, it has been accepted that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill. But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant*

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[56] *F v R (1982)* 33 SASR 189 at 194.
[57] Above n 56.
[58] Above n 56, 192-193
[59] Above n 38, [4.5]

profession or trade. Even in the sphere of diagnosis and treatment, the heartland of the skilled medical practitioner, the Bolam principle has not always been applied (See Albrighton v. Royal Prince Alfred Hospital (1980) 2 NSWLR 542, at pp 562-563 case of medical treatment). Further, and more importantly, particularly in the field of non-disclosure of risk and the provision of advice and information, the Bolam principle has been discarded and, instead, the courts have adopted (Albrighton v. Royal Prince Alfred Hospital (1980) 2 NSWLR, at pp 562-563; F v. R. (1983) 33 SASR 189, at pp 196, 200, 202, 205) the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to "the paramount consideration that a person is entitled to make his own decisions about his life" (F v. R. (1983) 33 SASR, at p 193).

And at 489:

However, the factors according to which a court determines whether a medical practitioner is in breach of the requisite standard of care will vary according to whether it is a case involving diagnosis, treatment or the provision of information or advice; the different cases raise varying difficulties which require consideration of different factors ((43) F v. R. (1983) 33 SASR, at p 191)… There is a fundamental difference between, on the one hand, diagnosis and treatment and, on the other hand, the provision of advice or information to a patient. In diagnosis and treatment, the patient's contribution is limited to the narration of symptoms and relevant history; the medical practitioner provides diagnosis and treatment according to his or her level of skill. However, except in cases of emergency or necessity, all medical treatment is preceded by the patient's choice to undergo it. In legal terms, the patient's consent to the treatment may be valid once he or she is informed in broad terms of the nature of the procedure, which is intended (44) Chatterton v. Gerson (1981) QB 432, at p 443). But

> *the choice is, in reality, meaningless unless it is made on the basis of relevant information and advice. Because the choice to be made calls for a decision by the patient on information known to the medical practitioner but not to the patient, it would be illogical to hold that the amount of information to be provided by the medical practitioner can be determined from the perspective of the practitioner alone or, for that matter, of the medical profession.*

Chief Justice Mason and Justices Brennan, Dawson, Toohey and McHugh's views were that medical opinion has a decisive role to play in making the determination on the doctor's standard of reasonable care however, whether the doctor conformed to that standard is something for the courts to decide.[60]

The judges emphasized that 'particularly in the field of non-disclosure of risk and the provision of advice and information, the Bolam principle has been discarded and instead, the courts have adopted the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care'[61]. 'The rationale behind the Bolam principle that expert matters can only be judged by expert opinion cannot be used to justify its application to determine doctor's duty of disclosure.'[62]

Nearly 7 years after *Rogers v Whitaker*, the Bolam principle as applied to provision of information or advice and to diagnosis and treatment was rejected in its entirety in *Naxakis v Western General Hospital*. The test that was formulated in *F v R* and *Rogers v Whitaker* whereby "the courts adjudicate on the appropriate standard of care" extended to cover all aspects of medical treatment including diagnosis and treatment and the provision of information or advice.

The facts of the case are as follows:[63]

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[60] Above n 6, 489.
[61] Above n 6, 487.
[62] Above n 38, [4.5].
[63] *Naxakis v Western General Hospital* (1999) 73 ALJR 782

> The patient was admitted to Western General Hospital suffering from a head injury. The patient underwent a CT scan and provisional diagnosis of subarachnoid haemorrhage was made. After admission, he lapsed into unconsciousness for five minutes and suffered various other symptoms including muscle spasms. He was treated in the hospital for several days. Two days after being discharged, he suffered a burst of aneurysm. As a result he suffered serious and permanent impairment. He claimed that surgeon had failed to consider the possibility of an aneurysm.

Justice Kirby in a majority judgment noted that 'it was open to the jury to infer that the neurosurgeon did not give due consideration to the possibility that an aneurysm was the underlying cause of the appellant's symptom rather than the minor trauma [and] if the jury had reached the conclusion that the neurosurgeon didn't consider the possibility of an alternative diagnosis of an aneurysm and the need for an angiogram, then the first step in establishing negligence would have been taken.'[64] Furthermore, the medical expert opinion that is provided must be scrutinized by the judiciary regardless of whether it is in relation to diagnosis and treatment or pertaining to provision of information or advice. In any event, it is for the courts to decide whether the doctor falls short of the standard of reasonable care.

This view in *Rogers v Whitaker* was later adopted in *Rosenberg v Percival* (2001) 205 CLR 434, where it was accepted that it is for the courts to determine the standard of care that is applicable to the medical profession.[65]

Gummow J in a majority judgment noted at 453:

> *It is important to understand the decision in Rogers in the context in which it was decided. Before Rogers dealt with the law in Australia, the law in England was that evidence of medical practice was the sole determinant of*

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[64] Above n 63.
[65] Above n 6, 487.

the appropriate standard. Thus, if evidence that it was the practice of a respected body of medical practitioners not to give a warning in the circumstances of the case were accepted by the tribunal of fact, any such failure to warn would not be negligent. This approach was described as the Bolam test. The decision of this Court in Rogers rejected the Bolam test. The Court held that the standard to be observed by medical practitioners was not to be determined solely or even primarily by medical practice. Rather, it was for the courts to judge what standard should be expected from the medical profession. In the joint judgment that standard was identified and fixed.

Justice Gummow rejected the Bolam principle and held that the standard of care owed by a doctor to his/her patient is for the court's determination.

From the analysis of the above cases, it is evident that reliance on professional medical opinion is one consideration in making the determination on the standard of reasonable care. However in the Australian jurisdiction, it is the courts that will have the final say on standard of reasonable care required of doctor's at law.

The recent case of *Rooke v Minister For Health & Ors* [2008] WADC 6 (18 January 2008) and *Wilson v Tier* [2008] NSWSC 92 (22 February 2008) have taken a similar approach to *Rogers v Whitaker* in rejecting the application of the Bolam principle to cases of medical negligence in relation to information giving in Australia.

(iii) Fiji Courts

The position in the Fiji jurisdiction is that there is still much support for the Bolam principle, however, there is evidence of a shift from applying the Bolam principle to the doctor's standard of care in the past medical negligence cases to a rejection of the same in certain few cases.

In *Wati v The Attorney General for Fiji*[66] Justice Fatiaki applied the Bolam Test[67] as the standard of care demanded of a doctor in Fiji. Justice Fatiaki in his judgment referred to the oft-cited direction given to the jury by Justice McNair in *Bolam v. Friern Hospital Management Committee* and to the dictum[68] of Lord Clyde in *Hunter v Hanley* in giving recognition to application of the Bolam principle to doctor's standard of care in Fiji.

In *Asaeli Naua Saulaki v Ministry of Health & The Attorney General of Fiji* (Unreported, High Court of Fiji, Civil Action No. HBC 354 of 2006, 21 July 2008) Justice Hickie in a single judgment noted at 14:

> *The Bolam test has been applied in the High Court of Fiji in the past decade in such cases as Wati v The Attorney General for Fiji (Unreported, High Court of Fiji, Civil Action No. HBC0222 of 1998, 12 September 2001, Fatiaki J (Paclii: (2001) FJHC 68, http://www.paclii.org/fj/cases/FJHC/2001/68.html) and Ismail v The Medical Superintendent and The Attorney General of Fiji (Unreported, High Court of Fiji, Civil Action No. HBC 310 of 1998, 25 July 2000, Shameem J (Paclii: (2001) FJHC 87, http://www.paclii.org/fj/cases/FJHC/2000/87.html).*
> *According to James Baledrokadroka writing in the Journal of South Pacific Law in 2002: "The Bolam test is still applied in the region as the standard of care that is required of a doctor." (See James Baledrokadroka, 'The Interface of Law and Medicine in the South Pacific', Journal of South Pacific*

[66] *Wati v The Attorney General for Fiji* (unreported, High Court of Fiji, Civil Action No. HBC0222 of 1998, 12 September 2001, Fatiaki J) http://www.paclii.org/fj/cases/FJHC/2001/68.html (Assessed 12 June 2008).

[67] `…where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the (ordinary) man… the test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.'

[68] `A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.'

Law, vol. 6, 2002, page 13 (Paclii:http://www.paclii.org/journals/fJSPL/vol06/9.shtml)

Both Counsel's in this particular instance referred to the Bolam principle as setting the standard of care demanded of doctors at law. Justice Hickie, in his judgment relied upon the cases of *Wati v The Attorney General for Fiji* and *Ismail v The Medical Superintendent and The Attorney General of Fiji* and James Baledrokadroka's article on *The Interface of law and Medicine in the South Pacific*[69] in giving recognition to the application of the Bolam principle to the doctors standard of care in Fiji.

James Baledrokadroka in an article on *The Interface of law and Medicine in the South Pacific* noted at 10:

> *In the High Court of Fiji case Wati v The Attorney General for Fiji (Civil Action No. 0222 of 1998) Fatiaki. J applied the Bolam Test as the standard of care required of a doctor in Fiji.*
>
> *However, in another High Court of Fiji case, Abdul Hafeez Ismail v The Medical Superintendent and The Attorney General of Fiji (Civil Action No. HBC of 1998), Shameem J. also applied the Bolam Principle but declined to follow the evidence of other doctors as to the standard of care*
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> *The application of the Bolam principle in the region is also seen as a way of determining the standard of duty in negligence cases. However, there are cases such as Abdul Hafeez Ismail v The Medical Superintendent and The Attorney General of Fiji (Civil Action No. HBC of 1998), where the courts seem to be moving away from the determination of standard and placing it with the courts where it truly belongs.*

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[69] James Baledrokadroka, 'The Interface of Law and Medicine in the South Pacific', (vol 6, 2002) *Journal of the South Pacific law* http://www.paclii.org/journals/fJSPL/vol06/9.shtml (Assessed 12 June 2008).

The application of the Bolam principle is still recognized in the Fiji jurisdiction with an exception of a few cases such as *Abdul Hafeez Ismail v The Medical Superintendent and The Attorney General of Fiji*[70] and *Arvind Kumar & Othrs v The Permanent Secretary for Health & The Attorney General of Fiji* (Unreported, High Court of Fiji, Civil Action No. 45 of 2004, 20 July 2006).

In *Abdul Hafeez Ismail v The Medical Superintendent and The Attorney General of Fiji* Justice Shameem in a single judgment noted at 4:

> *The medical staff at the CWM Hospital are judged by the standards of the ordinary, competent practitioner in the relevant field of medicine. The court may take into account the unique circumstances in which the doctors worked, such as the limited resources and facilities of the CWM Hospital. However a specialist is expected to exercise the standard of care of a reasonably competent specialist, and a registrar the standard of care of a reasonably competent registrar.*

Justice Shameem in her judgment clarified the standard of care required of doctors in Fiji, namely 'a specialist is expected to exercise the standard of care of a reasonably competent specialist and a registrar the standard of care of a reasonable competent registrar'.[71] This view is similar in approach to the application of the Bolam standard of care. However in this particular instant, Justice Shameen applied the Bolam principle but 'declined to follow the evidence of other doctors as to the standard of care'[72].

The shift away from the application of the Bolam principle was noted in *Arvind Kumar & Othrs v The Permanent Secretary for Health & Attorney General of Fiji*.

[70] *Abdul Hafeez Ismail v The Medical Superintendent and The Attorney General of Fiji* (Unreported, High Court of Fiji, Civil Action No. HBC of 1998 Shammem J) http://www.paclii.org/fj/cases/FJHC/2000/87.html (Assessed 12 June 2008).
[71] Above n 70, 4.
[72] Above n 69, 10.

Justice Pathik in a single judgment noted at 18:

> *One can safely deduce from the cases that a doctor could be liable for negligence in respect of diagnosis and treatment despite a body of professional opinion sanctioning his/her conduct where it has not been demonstrated to Court's satisfaction that the body of opinion relied on was reasonable or responsible. It boils down to saying that it is the Court not for medical opinion to decide what standard of care required is of a professional in the circumstances of each particular case.*

Justice Pathik adopted the views expressed in *Rogers v Whitaker* and followed the Australian approach whereby it is for the courts to make the determination on the standard of reasonable care owed by a doctor to his/ her patient.

It is submitted that a possible criticism of Justice Pathik's decision is that it fails to recognize the unique cultural and social position in Fiji which is different from Australia. According to the 2007 *Population Census*[73], the total population of Fiji is 837, 271. The Fiji Islands Bureau of Statistics[74] states that approximately 35% of the population in Fiji lives below poverty line and the Minister for Education Mr. Filipe Bole whilst addressing the 101st Fiji Principal's Association Conference at Fiji College of Advance Education in Nasinu stated that 'approximately 15 % of the school student's dropout at class 8'[75]. These figures indicate that the literacy and economical situation in Fiji is different. In Fiji, most people requiring medical treatment are living below poverty line. The people in the rural areas are less educated and traditional in their approach therefore they have a tendency not to question their doctors. They do not have the sufficient knowledge to understand about human anatomy and/or the medical information given to them concerning their health. They do not want to be involved in the decision making process in regards to

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[73] 'Population Census 2007' , http://www.statsfiji.gov.fj/ (Assessed 23 April 2009).

[74] 'Poverty Indicators' , http://www.statsfiji.gov.fj/Social/poverty_indicators.htm (Assessed 23 April 2009).

[75] Monika Singh, 'Dropouts rise: 15pc of our kids don't survive primary school' *Fiji Times Online* (Suva, Fiji Island) 24 April 2008, http://www.fijitimes.com/story.aspx?id=87209 (Assessed 23 April 2009).

the choice of their medical treatment. On most occasions, they tend to rely on the doctor to make the choice of medical treatment for them.

The Fijians have bestowed the title of "*vuniwai*" onto doctors. The title is one of respect and the treatment given by the "*vuniwai*" is taken very seriously. It is a traditional belief that the treatment provided will work even before the patient has undergone the said treatment. The literacy factor also raises issues about the ability of patients to communicate and understand the information imparted to them by their doctors. The economic situation and the costly medical bills in the private health care tend to sway most of these people to access the public health care facilities. The public hospitals are under resourced with limited beds, medical equipments and treatment facilities. They are understaffed with most of the doctors overworked. The surgical patients tend to be on the waiting list for months before undergoing treatment. In situations like this, it is a relief to the patient to receive any sort of treatment instead of waiting in pain and agony.

Adopting the Australian standards of treatment and disclosure of risks in *Rogers v Whitaker* into the Fiji context will give rise to defensive medicine [76] which will inevitably increase the medical bill borne by patients. The Australian economy is able to bear the higher costs of the Australian health care whereas Fiji's economy is not even in a position to entertain such a proposition. There are only 17 Consultants employed in public health care in Fiji. This includes one Consultant Surgeon, one Consultant Ear, Nose & Throat specialist, one Consultant Urologist, one Consultant Pathologist, two Consultant Radiologist, two Consultant Orthopaedics, 3 Consultant Obstetrics & Gynecologists and five Consultant Physicians. This data reflects the status as it was in April 2009. In view of the unique cultural and social position in Fiji as well as taking into account the harsh realities of the health care system, it is recommended that the Bolam standard of care should be applicable to diagnosis and

[76] This means that the doctors will carry out various diagnostic tests on the patients which would be costly and unnecessary in certain circumstances just to avoid any claims of negligence. The medical indemnity insurance premiums for the private practitioners will inevitably rise and this will be reflected in the higher fees implemented which will eventually be borne by the patient.

treatment and provision of information or advice. This standard should be that a doctor is not guilty of negligence if he/she has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.

1.133 Causation

Causation plays a significant role in medical negligence cases. 'Causation proves a direct link between the defendant's negligence and the claimant's loss and damage.'[77] 'No matter how gross the defendant's negligence he is not liable if, as a question of fact, his conduct did not cause the damage.'[78]

The emphasis is on, 'how in fact did the damage occur?'[79] 'In medical malpractice litigation this issue is largely a matter of medical and scientific evidence… normally dealt with by the "but for" test.'[80]

(i) English Jurisdiction

In the English jurisdiction, 'if the damage to the claimant would have not occurred "but for" the defendant's negligence then the negligence is the cause of the damage'[81]. This test has been applied in *Barnett v Chelsea and Kensington Hospital Management Committee* [1968] 1 All ER 1068.

The facts of the case are as follows:[82]

> The patient visited the hospital complaining of vomiting after drinking tea. The casualty officer, a doctor, who himself was not well, did not see them

[77] 'Causation in English Law', http://en.wikipedia.org/wiki/Causation_in_English_law (Assessed 3 April 2009).
[78] Michael A Jones, *Medical Negligence* (4th ed, 2008) at 442.
[79] Above n 78.
[80] Above n 78.
[81] Above n 78, 443.
[82] *Barnett v Chelsea and Kensington Hospital Management Committee* [1968] 1 All ER 1068.

and sent them home advising them to consult their own doctor. The patient some hours later died of arsenical poisoning.

Justice Nield in a single judgment noted at 1069:

That the plaintiff has failed to establish, on the balance of probabilities, that the deceased's death resulted from the negligence of the defendants, my view being that, had all care been taken, the deceased might still have died.

Justice Nield applied the "but for" test and concluded that the defendant's negligence is not the cause of the deceased's death. 'The courts have gone some way to relieving a claimant from the rigours of the "but for" test where the difficulty of establishing causation has been a product of scientific uncertainty.'[83] This exception to the "but for" test has been stated in *Bonnington Castings Ltd v Wardlaw* [1956] 1 All ER 615.

The facts of the case are as follows:[84]

The respondent, a worker at the dressing shop of a foundry producing steel castings, contracted pneumoconiosis through inhaling air which contained silica dust. The silica dust in the air was from the operation of the pneumatic hammers used by the respondent and part from the operations conducted at swing grinders. There was issue as to the source of the dust leading to the respondent's condition.

Lord Reid in a majority judgment noted at 618:

It would seem oblivious in principle that a pursuer or plaintiff must prove not only negligence or breach of duty but also that such fault caused, or

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[83] Above n 78, 460.
[84] *Bonnington Castings Ltd v Wardlaw* [1956] 1 All ER 615.

materially contributed to, his injury, and there is ample authority for that proposition both in Scotland and in England.

Lord Reid emphasized that in relation to the issue on causation, the plaintiff must prove that the negligence of the defendant's caused or "materially contributed" to his injury.[85] This test of 'material contribution" was applied to damages in this particular instant. 'Subsequently, the House of Lords appeared to take *Bonnington Castings Ltd v Wardlaw* one step further'[86] and apply the test of "material contribution" to the risk in *McGhee v National Coal Board* [1972] 3 All ER 1008.

The facts of the case are as follows:[87]

> The claimant, a worker at the defendant's brick kilns, contracted dermatitis as a result of exposure to the brick dust. There was no adequate washing facility provided by the defendant. The claimant brought a claim against the defendant claiming damages at common law in respect to his employer's fault in failing to provide adequate washing facilities.

Lord Wilberforce in a majority judgment noted at 1012:

> *It is a sound principle that where a person has, by breach of duty of care, created a risk, and injury occurs within the area of risk, the loss should be borne by him unless he shows that it had some other cause…Pneumoconiosis being a disease brought on by cumulative exposure to dust particles, the courts have held that where the exposure was to a compound aggregate of 'faulty' particles and 'innocent' particles, the workman should recover, so long as the addition of the 'faulty' particles and 'innocent' particles (ie those*

[85] Above n 84, 618.
[86] Above n 78, 461.
[87] *McGhee v National Coal Board* [1972] 3 All ER 1008.

> *produced by some fault of the employers) was material, which I take to mean substantial, or not negligible (Bonnington Castings Ltd v Wardlaw).*

'The House of Lords held the defendants liable on the basis that it was sufficient for a claimant to show that the defendant's breach of duty made the risk of injury more probable even though it was uncertain whether it was the actual cause.'[88]

In *Chatterton v Gerson*, Justice Bristow applied the subjective test in ascertaining causation. The test applied was whether the plaintiff in the circumstances would have refused the treatment, if told about the risks. The application of the objective test (whether a reasonable person in the circumstances would have refused the treatment, if told about the risks) was not preferred by the court as the issue of the causation is 'based on evidence about the patient, the patient's treatment, circumstances, and expressed views'[89].

The application of the Bolam principle to the issue of causation was criticized in *Bolitho v. City and Hackney Heath Authority*.

Lord Browne-Wilkinson in a majority judgment noted at 776:

> *Where, as in the present case, a breach of a duty of care is proved or admitted, the burden still lies on the plaintiff to prove that such breach caused the injury suffered (see Bonnington Castings Ltd v Wardlaw [1956] 1 All ER 615, [1956] AC 613 and Wilsher v Essex Area Health Authority [1988] 1 All ER 871, [1988] AC 1074). In all cases, the primary question is one of fact: did the wrongful act cause the injury? But in cases where the breach of duty consists of an omission to do an act which ought to be done (eg. The failure by a doctor to attend) that factual inquiry is, by definition, in the realms of hypothesis. The question is what would have happened if an*

[88] Above n 78, 461.
[89] Above n 25.

event which by definition did not occur, had occurred… Therefore the Bolam test had no part to play in determining the first question, viz what would have happened?

And at 777:

There were, therefore, two questions for the judge to decide on causation: (1) What would Dr Horn have done, or authorised to be done, if she had attended Patrick? (2) If she would have intubated, would that have been negligent? The Bolam test has no relevance to the first of those questions but is central to the second.

Lord Browne-Wilkinson held that the Bolam test has no application in deciding questions of causation.[90] 'Another way of putting this is to say that causation is about *what in fact happened,* which in turn depends upon the hypothetical question of *what would have happened* had there been no negligence ("but for" the negligence would the damage have occurred?).'[91]

The conventional principles of causation based on the "but for" test has been applied subjectively in failure to warn cases in the English jurisdiction in the circumstances where the plaintiff's view is that he/she would have refused the treatment if informed about the risks. However, do the principles of causation still apply in circumstances where the plaintiff's view is that he/she would have delayed his/her decision on whether to undergo the treatment there and then, if informed of the risks? This particular circumstance was taken into consideration on policy grounds in *Chester v Afshar* [2004] 4 All ER 587.

Lord Hope in a majority judgment noted at 610-611:

[90] Above n 50, 776.
[91] Above n 78, 448.

> *I would accept that a solution to this problem which is in Miss Chester's favour cannot be based on conventional causation principles. The 'but for' test is easily satisfied, as the trial judge held that she would not have had the operation on 21 November 1994 if the warning had been given. But the risk of which she should have been warned was not created by the failure to warn. It was already there, as an inevitable risk of the operative procedure itself however skilfully and carefully it was carried out. The risk was not increased, nor were the chances of avoiding it lessened, by what Mr Afshar failed to say about it. As Professor Honore in his note 'Medical non-disclosure, causation and risk: Chappel v Hart" (1999) 7 Torts Journal 1 at 4 has pointed out, to expose someone to a risk to which that person is exposed anyhow is not to cause anything.*

> And at 612:

> *On policy grounds therefore I would hold that the test of causation is satisfied in this case. The injury was intimately involved with the duty to warn. The duty was owed by the doctor who performed the surgery that Miss Chester consented to. It was the product of the very risk that she should have been warned about when she gave her consent. So I would hold that it can be regarded as having been caused, in the legal sense, by the breach of that duty.*

Lord Hope in his judgment agreed with Professor Honore's view that in circumstances where there is an 'absence of casual connection'[92] the test of causation can still be applied since 'the injury which she suffered at the hands of [the doctor] was within the scope of the very risk which he should have warned her about when he was obtaining her consent to the operation which resulted in that injury'[93].

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[92] *Chester v Afshar* [2004] 4 All ER 587 at 612.
[93] Above n 92.

From the analysis of the above cases, it is important to note that *Chatterton v Gerson*, a failure to warn case applied a subjective test to the question of causation. The issue of causation was decided on whether the patient in the circumstances would have refused the treatment, if told of the risks, whereas *Bolitho v City and Hackney Health authority* which is not a failure to warn case applied an objective test. The test applied was whether a reasonable person would have refused the treatment, if the risks were known to him/her. The application of the subjective test to the question of causation in a failure to warn case was noted in *Chester v Afshar*. The circumstances of the case were different since in *Chatterton v Gerson*, Miss Chatterton's view was that she would not have undergone the treatment if she was informed of the risks, whereas in *Chester v Afshar*, Miss Chester advised the court that if she was told of the risks she would not have undergone the treatment there and then but would have delayed her treatment and sought second or probably third medical opinion before making the decision. Lord Hope held that the conventional principles of causation will not be applicable since it's easy to establish the '"but for" test. However, Lord Hope applied policy considerations to the test of causation and held that the test of causation is satisfied on policy grounds and in making that determination, Lord Hope applied the subjective approach to the issue of causation.

(ii) Australia Jurisdiction

The position in Australia is similar to the English jurisdiction, whereby the determination of causation is based on the subjective test. The emphasis is on whether the plaintiff in the circumstances would have refused the treatment if he/she was informed about the risks. This view is stated in *Chappel v Hart* [1998] 156 ALR 517.

The facts of the case are as follows:[94]

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[94] *Chappel v Hart* [1998] 156 ALR 517.

> The appellant operated on the respondent's oesophagus. During the operation the oesophagus was perforated and there ensued an infection which resulted in damage to one of the respondent's vocal cords and consequential partial loss of her voice. The appellant failed to inform the respondent the risks of the treatment.

Justice Gummow in a majority judgment noted at 535:

> *In Mrs Hart's case, the very risk of which she should have been warned materilised... Dr Chappel conceded that, if the surgery had been performed at a different time, then "[i]n all likelihood" Mrs Hart 'would not have suffered the random chance of injury". In addition, the particular risk involved had been the subject of a specific inquiry by Mrs Hart of the medical practitioner who then was engaged by her to perform the surgery. She was a person whom the potential consequences of damage to her voice were more significant than the "statistical" risk. Those additional factors combined with the satisfaction of the "but for" test were sufficient to establish causation in this case.*

This subjective approach to the issue of causation was adopted and followed in the English case of *Chester v Afshar*. Justice Gummow indicated that the additional factors[95] combined with the satisfaction of the 'but for" test were sufficient to establish causation in this case. This approach is similar to the English jurisdiction whereby issues of causation in failure to warn cases are determined by a subjective test. 'That is, the decision whether the patient would have refused treatment if told of the risk in question is based on evidence about the patient, the patient's treatment, circumstances, and expressed views, rather than on consideration of a reasonable person in the patient's position.'[96]

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[95] The additional factors that needs to be taken into consideration are: whether the particular risk has been the subject of specific inquiry by the patient, whether the consequences of the damage to the patient was more significant than the "statistical risk", the circumstances of the patient (see Above n 94, 535)
[96] Above n 25.

The court in *Chappel v Hart* was decided by a majority of three (Gaudron, Gummow and Kirby JJ) to two (McHugh and Hayne JJ). 'This Australian case reveals two fundamentally different approaches, one favoring firm adherence to traditionalist causation techniques and the other a greater emphasis on policy and corrective justice.'[97] The majority held that 'there was casual connection between failure to warn and the [injury sustained by Dr Chappel, whereas the minority were of the view] that causation has not been established [since] the defendant did not increase the risk to which [Dr Chappel] was exposed when she underwent the operation'[98].

Justice McHugh in a minority judgment noted at 526:

> *The inquiry as to what the plaintiff would have done if warned is necessarily hypothetical. But if the evidence suggests that the acts or omissions of the defendant would have made no difference to the plaintiff's course of action, the defendant has not caused the harm which the plaintiff has suffered.*

Justice Hayne also delivered a minority judgment and agreed with Justice McHugh 'that there is insufficient evidence in this case to say, on the balance of probabilities, that the appellant's failure to warn exposed the respondent to greater risk of injury'[99].

It is submitted that the majority view is important as it provides remedy to the patient in situations where the patient's view is that he/she would not have undergone the treatment there and then if informed of the risks. Though the minority judgment is logical and raises a strong argument but it fails to remedy a litigant. The purpose of the law is to provide protection to the patient. The doctor has a duty to warn the patient of the risks. It is for the patient to decide whether to undergo the treatment. 'If the doctor's failure to take that care results in [the patient] consenting to an operation to which [he/she] would not have otherwise given the consent, the

[97] Above n 92, 595.
[98] Above n 92, 605.
[99] Above n 92, 607.

purpose of that rule would be thwarted if [the doctor] was not to be held responsible when the very risk about which [he/she] failed to warn [the patient] materialises and causes [him/her] an injury which [the patient] would not have suffered then and there.'[100]

Furthermore, just because a litigant is honest in his reply to the question on causation that he/she would not have undergone the treatment there and then and possibly delayed that decision subject to another medical opinion does not mean that the litigant should be left without remedy in the situation where the risk materializes and causes the patient an injury. The majority judgment in this case sets the principle that justice will be done despite the absence of casual connection.[101]

The application of this subjective test to the issue of causation was applied in a failure to warn case of *Rosenberg v Percival.*

The facts of the case are as follows:[102]

> The patient underwent surgery to his jaw and suffered complications resulting in a severe permanent disorder. 'The surgery had been performed without negligence but the surgeon had not warned the patient of the risk of the particular complication.'[103]

Justice McHugh in a majority judgment noted at 453:

> *Under the Australian common law, in determining whether a patient would have undertaken surgery, if warned of a risk of harm involved in that surgery, a court asks whether this patient would have undertaken the surgery. The test is a subjective test… It follows from the test being*

[100] *Chester v Afshar* [2002] 3 All ER 552 at 572.
[101] Professor Tony Honore, 'Medical non-disclosure, causation and risk: Chappel v Hart' (1999) 7 (1) *Torts Law Journal* 1 at 8.
[102] *Rosenberg v Percival* (2001) 205 CLR 434.
[103] Above n 102.

> *subjective that the tribunal of fact must always make a finding as to what this patient would have done if warned of the risk. In some cases where there is no direct evidence as to what the patient would have done, the judge may infer from the objective facts that the patient would not have undergone the procedure. In exceptional cases, the judge may even reject the patient's testimony as not credible and then infer from the objective facts that the patient would not have proceeded… Yet, notwithstanding the rejection of the patient's oral testimony, the judge might infer that nevertheless this patient would not have undergone the procedure. That inference would ordinarily be based not only on the objective facts but also on the tribunal's assessment of the general character and personality of the patient*

Justice Gummow also delivered a majority judgment and agreed with Justice McHugh that the test applied to causation in failure to warn cases in Australia is a subjective one and 'the court must deal with hypothetical considerations as to what the patient in question would have done had a warning been given'.[104]

From the analysis of the above cases, it is evident in the Australian jurisdiction that a subjective test is applied to the question of causation in failure to warn cases. The test is what the particular patient would have done if informed of the risks. However, the court in *Rosenberg v Percival* goes further to exercise its discretion in relation to the patient's view. The court held that in the circumstances 'where there is no direct evidence as to what the patient would have done, the judge may infer from the objective facts that the patient would not have undergone the procedure'.[105] Furthermore, 'in exceptional cases, the judge may even reject the patient's testimony as not credible and then infer from the objective facts that the patient would not have proceeded'.[106] The court held that even if the oral testimony of the patient is rejected, the judge might infer nevertheless this patient would not have undergone

[104] Above n 102, 462.
[105] Above n 102, 453.
[106] Above n 102, 453.

the treatment based on the objective facts combined with the tribunal's assessment of the general character and personality of the patient.[107]

It was noted in the Australian jurisdiction that the additional factors combined with the "but for" test was sufficient to establish causation. These additional factors include questions on specific inquiry about the risks, the consequences of the damage to the patient as oppose to the "statistical risks" and the circumstances of the patient. The court held that 'the "but for" test… remains a relevant criterion for determining whether the breach of duty demonstrated is a cause of the plaintiff's damage, however it is not the exclusive test nor is it sufficient on its own to demonstrate the casual link for legal purposes'.[108] Furthermore the court went onto say that 'a sufficient casual connection will… be established if it appears that the plaintiff would not have suffered the damage complained of but for the defendant's breach of duty henceforth the court has simply added the warning that it is necessary to temper the results thereby produced with "value judgments" and "policy considerations".'[109] This view that the "but for" test together with the combination of "policy considerations" was sufficient to establish causation in *Chappel v Hart* and it was adopted in the English case of *Chester v Afshar*. This view provides a direction in failure to warn cases where there is an absence of a casual link and in doing so, applies a subjective test to the issue of causation.

The principles of causation have been codified as part of Australian Tort Reform, adopting the approach by McHugh and Hayne JJ, who dissented in *Chappel v Hart*. For example, section 5D (3) of the *Civil Liability Act* (NSW) modified *Rosenberg v Percival* by providing 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.' This is similar in approach to the State of Queensland whereby section 11 (3) of the *Civil Liability Act* (QLD) has codified the same.

[107] Above n 102, 453.
[108] Above n 94, 545 (majority judgment of Justice Kirby).
[109] Above n 94, 545 (majority judgment of Justice Kirby).

Part 1I: Statutory Approach to Consent to Medical Treatment

2.1 Tracing Developments through Ethical Consideration to Statutory Application

Apart from the application of common law principles through judge made law, some of these principles have been codified into codes of ethics and legislation.

'Medical Ethics is defined, as a civil code of behavior considered correct by members of the profession for the good of both the patient and profession.'[110] 'The need for a patient's trust in his doctor is the basis for ethical codes from many centuries ago as manifested in the traditions of all the major civilizations.'[111] 'In recent times, national, regional and world associations of doctors as well as other health care professionals have revised existing codes of ethics and formulated new ones to keep up with advances in medical knowledge, medical practice and research as well as changes in society.'[112]

These Codes of Ethics inform the [legislation] and nevertheless they have 'frequent areas of overlap'[113]. 'Law is derived and/or expressed through the Constitution, statutes, regulations and the case law [whereas] medical ethics is derived and/or expressed through the Law, institutional policies/practices, policy of professional organizations, professional standards of care and fiduciary obligations.'[114] Both the Codes of Ethics and the legislation tend to address issues on consent to medical treatment and doctors duty to warn of risks to treatments.

A distinction between medical ethics and law is that the decision made by a court is enforceable.[115] 'A statute or administrative code sets a general standard of conduct, which must be adhered to or civil/criminal consequences may follow a breach of the

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[110] 'Code of Medical Ethics' (2002) http://www.bhanot.net/MMA/EthicsCode.pdf (Assessed 7 June 2008).
[111] Above n 110.
[112] Above n 110.
[113] 'Law and Medical Ethic' (2008) http://www.medceu.com/index/index.php?page=get_course&courseID=2017&nocheck (Assessed 7 April 2009)
[114] Above n 113.
[115] Above n 113.

standard.'[116] 'Conversely, an ethics pronouncement which is not adopted into law may be a significant professional and moral guidepost but it is generally unenforceable.'[117] 'Lawmakers (courts and legislatures) frequently do turn to the policy statements (including any medical ethics statements) of professional organizations when crafting laws affecting [medical] profession.'[118]

Common law jurisdictions of the United Kingdom, Australia, New Zealand, Fiji and Canada have one way or the other incorporated certain provisions into their legislation to safeguard the interests of individuals in respect of their choice to consent to medical treatment. This is known as the statutory approach taken by lawmakers in their respective jurisdictions. However, with the exclusion of South Australia and Canada, there has been no legislation to govern the general practice of medicine. Provisions dealing with consent to medical treatment have either been reflected in the *Mental Health Act* or the *Guardianship Act*. The reason for this is so that the special needs of people with disability can be taken into account. The statutory approach is limited in its application since it only applies in certain circumstances to people with mental disability and in the case of minors. However, it is helpful to look at these statutory schemes to have an overview of considering a wider statue of general application.

(i) English Jurisdiction

The British Medical Association (BMA) Code of Ethics was revised in 2007 to be in line with the *Mental Health Act 2007* (UK). Chapter 2 of the BMA code concerns consent and refusal to medical treatment by competent adults, Chapter 3 deals with treatment without consent by incapacitated adults and compulsory treatment and Chapter 4 concerns consent and refusal to medical treatment by children and young people.

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[116] Above n 113.
[117] Above n 113.
[118] Above n 113.

The *Mental Health Act 2007* (UK) amended the *Mental Health Act 1983* (UK) and the *Mental Capacity Act 2005* (UK) and received Royal Assent on 19th July 2007. Part IV of the *Mental Health Act 1983* (UK) deals with consent to treatment and Part II refers to guardianship provisions. The *Mental Capacity Act 2005* (UK) provides provisions for advance decisions to refuse treatment.

Advance directives or 'living wills' are also a means of making decisions pertaining to medical care. This is about a decision that will be made by a competent person about future treatment. Advance directives are used by physicians in circumstances whereby the patient does not have the capacity to provide consent to medical treatment. The United Kingdom Law Commission Report 231 on *Mental Incapacity*[119] recommended 'the introduction of a new form of power of attorney to be called a "Continuing Power of Attorney" (CPA)'[120]. 'The CPA may extend to matters relating to a donors personal welfare, health care, property and affairs including the conduct of legal proceedings.'[121] 'The Commission also recommended that attorneys should be expressly authorized in the power appointing them to consent to any of the treatments or procedures which it recommends should require some sort of independent supervision (either by the court, a second opinion doctor or in relation to non-therapeutic research , the new Mental Incapacity Research Committee).'[122]

(ii) Australia Jurisdiction

Australia is a federation of six States and two territories and each of the six States has their own statute to deal with health matters. The Australian Medical Association (AMA) Code of Ethics was revised in 2006. The AMA code provides standard guidelines pertaining to the ethical behavior expected of doctors.

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[119] UK Law Reform Commission, *Mental Incapacity*, Report No 231 (1995) http://www.lawcom.gov.uk/summary_recommendations.htm#fn1 (Assessed 15 April 2009).
[120] Above n 119.
[121] Above n 119.
[122] Above n 119.

Part 1.1 (k) stipulates that the doctors must:

> *Respect your patient's right to choose their doctor freely, to accept or reject advice and to make their own decisions about treatment or procedures*

The *Mental Health Act* (NSW) came into effect in 2007. Section 91 of the said Act refers to informed consent requirements[123] regarding electro convulsive therapy (ECT) and section 92 refers to persons impaired by medication incapable of giving informed consent in an electro convulsive treatment. It is important to note that these provisions only applies to ECT and is not applicable to any other treatment under the said Act. These informed consent requirements are similar in application to the common law principles of explanation and disclosure set out in *Rogers v Whitaker*. ECT is a medical treatment that involves the passing of small electric currents through the brain. Sections 100 & 101 of the said Act provide powers to the Director-General and to the Tribunal to give consent to perform surgery on an involuntary patient suffering from mental illness.

Similar provisions of full explanation and disclosure in relation to informed consent requirements[124] regarding ECT is reflected in section 137 of the *Mental Health Act 2000* (QLD). This Act is amended by the *Mental Health and other Legislation Amendment Act 2007* (QLD). However, provisions pertaining to informed consent remain the same. Section 134 of the said Act provides that the person must have capacity to give consent and section 135 states that informed consent must be in writing signed by the person. Section 136 of the said Act states that informed consent must be given freely and voluntarily.

ECT is a specific invasive treatment and that is why considerations of informed consent are relevant. Specific Invasive treatments are those treatments which are irreversible and carry a gravity of consequences. For the purposes of this thesis, a

[123] These informed consent requirements are stated in 3.2.
[124] These informed consent requirements are stated in 3.2.

specific invasive procedure means a sterilization, abortion, blood transfusion and ECT.

The *Guardianship Act 1987* (NSW) also contains provisions dealing with situations in which individuals are incapable of giving medical consent or making decision with respect to the choice of medical treatment or procedure to be undertaken. Section 36 (1) of the said Act stipulates that consent may be given in a case of a minor or major treatment by the person responsible or in any case by the Tribunal and section 37 deliberates on when treatment might be carried out on any such consent. Section 40 looks into consent given by persons responsible for patients whereas the effects of consent are reflected under section 46 of the said Act. Section 46A provides power to the guardian to override a patient's objection to treatment when authorized by the Tribunal.

Similar provisions are also reflected in the *Guardianship and Administration Act 2000* (QLD). Chapter 4 Part 3 of the said Act provides powers to the Tribunal to give consent in special health care matters such as sterilization[125] and termination of pregnancy[126]. This Act was amended by the *Guardianship and Administration and other Acts Amendment Act 2008* (QLD). However the above provisions in Chapter 4 Part 3 were not amended.

Apart from people with mental disability, there are other examples where the law concerning duty to warn of risks to treatments has been enshrined in statutes. The *Civil Liability Act 2003* (QLD) has codified the provisions pertaining to common law principles of standard of care and doctors duty to warn of risks.

Section 21 (1) of the *Civil Liability Act 2003* (QLD) refers to doctor's duty to warn of risks to treatments:

[125] *Guardianship and Administration Act 2000* (QLD) s 70.
[126] Above n 125, s 71.

A doctor does not breach a duty owed to a patient to warn of risk, before the patient undergoes any medical treatment (or at the time of being given medical advice) that will involve a risk of personal injury to the patient, unless the doctor at that time fails to give or arrange to be given to the patient the following information about the risk--

(a) information that a reasonable person in the patient's position would, in the circumstances, require to enable the person to make a reasonably informed decision about whether to undergo the treatment or follow the advice;

(b) information that the doctor knows or ought reasonably to know the patient wants to be given before making the decision about whether to undergo the treatment or follow the advice.

Section 22 of the said Act stipulates the standard of care for professionals:

(1) A professional does not breach a duty arising from the provision of a professional service if it is established that the professional acted in a way that (at the time the service was provided) was widely accepted by peer professional opinion by a significant number of respected practitioners in the field as competent professional practice.

(2) However, peer professional opinion can not be relied on for the purposes of this section if the court considers that the opinion is irrational or contrary to a written law.

(3) The fact that there are differing peer professional opinions widely accepted by a significant number of respected practitioners in the field concerning a matter does not prevent any 1 or more (or all) of the opinions being relied on for the purposes of this section.

(4) Peer professional opinion does not have to be universally accepted to be considered widely accepted.

(5) This section does not apply to liability arising in connection with the giving of (or the failure to give) a warning, advice or other information, in relation to the risk of harm to a person, that is associated with the provision by a professional of a professional service.

It is important to note that section 22 of the said Act is not applicable to failure to warn cases. This Act is amended by the *Civil Liability (Dust Diseases) and other legislation Amendment Act 2005* (QLD). However, the above provisions remain the same.

Similar statutory provision in relation to the standard of care for professionals is stipulated in section 5O of the *Civil Liability Act 2002* (NSW):

(1) A person practising a profession ("a professional") does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.

(2) However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.

(3) The fact that there are differing peer professional opinions widely accepted in Australia concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purposes of this section.

(4) Peer professional opinion does not have to be universally accepted to be considered widely accepted.

This section does not apply to duty to warn of risks to treatments. Pursuant to section 5P of the said Act, this provision does not apply to liability arising in connection with the giving of (or the failure to give) a warning, advice or other information in respect of the risk of death of or injury to a person associated with the provision by a professional of a professional service. This Act has been amended by the *Civil Liability Amendment Act 2006* (NSW). However, the above provisions remain the same.

However, South Australia has enacted legislation to address concerns in the area of consent to medical treatment. This Act is known as the *Consent to Medical Treatment and Palliative Care Act 1995* (SA). Part 2 of the said Act has provision dealing with consent to medical treatment. Division 3 refers to medical powers of attorney and Division 4 refers to administration of medical treatment to children. Division 5 has provisions dealing with emergency medical treatment.

Section 15 of the said Act stipulates that:

A medical practitioner has a duty to explain to a patient (or the patient's representative), so far as may be practicable and reasonable in the circumstances—

(a) the nature, consequences and risks of proposed medical treatment; and

(b) the likely consequences of not undertaking the treatment; and

(c) any alternative treatment or courses of action that might be reasonably considered in the circumstances of the particular case.

This duty to warn is similar in approach to the common law principles of full explanation and disclosure in *Rogers v Whitaker*. This Act was amended by the

Consent to Medical Treatment and Palliative Care (Prescribed Forms) Amendment Act 2004 (SA). However, the above provisions remain the same.

This Act contains the principles of guardianship and care of children but fails to provide guidance on mentally ill patients. The reason for this is so that their special needs are taken into account under the *Mental Health Act 1993* (SA).

(iii)New Zealand Jurisdiction

The New Zealand Medical Association (NZMA) Code of Ethics 2002 contains provisions to safeguard the interests of individuals to make decisions in regards to their choice of medical treatment or procedure. 'Respect the rights of patient' and 'respect the patient's autonomy and freedom of choice' is stipulated under Clause 2 & 3 of the NZMA code.

The *Mental Health (Compulsory Assessment and Treatment) Act* was enacted in 1992. Section 67 of the said Act refers to the right of patient's to be informed about medical treatment and section 87 states the age of consent as 16 years. This Act was amended by the *Mental Health (Compulsory Assessment and Treatment) Act 1999* and *Mental Health (Compulsory Assessment and Treatment) Act 2003*. However, the above provisions remain the same.

Section 67 of the *Mental Health (Compulsory Assessment and Treatment) Act 1992* stipulates that:

> *Every patient is entitled to receive an explanation of the expected effects of any treatment offered to the patient, including the expected benefits and the likely side effects, before the treatment is commenced*

The *Health and Disability Commissioner Act 1994* amended by the *Health and Disability Commissioner Amendment Act 2007* protects and safeguards the interest

of New Zealand Consumers through the *Code of Health and Disability Services Commissioners Rights 1996.* Unlike the Mental Health legislation in the United Kingdom and Australia jurisdictions, this Act actually defines informed consent:

> *Informed consent, in relation to a health consumer on or in respect of whom there is carried out any health care procedure, means consent to that procedure where that consent—*
>
> *(a) Is freely given, by the health consumer or, where applicable, by any person who is entitled to consent on that health consumer's behalf; and*
>
> *(b) Is obtained in accordance with such requirements as are prescribed by the Code*

Right 6 of the *Code of Health and Disability Services Commissioners Rights 1996* states that the consumers have the right to be fully informed:

> *1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –*
>
> *a) An explanation of his or her condition; and*
>
> *b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and*
>
> *c) Advice of the estimated time within which the services will be provided; and*
>
> *e) Any other information required by legal, professional, ethical, and other relevant standards; and*
>
> *f) The results of tests; and*
>
> *g) The results of procedures.*

2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

3) Every consumer has the right to honest and accurate answers to questions relating to services, including questions about -

a) The identity and qualifications of the provider; and

b) The recommendation of the provider; and

c) How to obtain an opinion from another provider.

Right 7 (1) of the said Code states that services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this code provides otherwise.

The standard prescribed by Right 6(1) and (2) of the *Code of Health and Disability Services Consumers Rights 1996* is the 'reasonable patient test' modeled on the Australian case law of *Rogers v Whitaker.*

The New Zealand jurisdiction has separate legislation concerning people with mental disability and the reason for this is so that their special needs are best taken into account.

(iv) Canadian Jurisdiction

Canada is a federation of ten provinces and three territories and each of the ten provinces has their own statute to deal with health matters. 'The major difference between a Canadian province and a territory is that a province receives its power and

authority directly from the Crown, via the Constitution Act, 1867, whereas territories derive their mandates and powers from the federal government.'[127]

The Canadian Medical Association (CMA) Code of Ethics 2004 contains provisions in respect to consent to medical treatment.

Part 21 of the said Code states that:

> *Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability.*

Part 24 of the said Code recognizes the rights of a competent patient to either consent or refuse to consent to medical treatment:

> *Respect the right of a competent patient to accept or reject any medical care recommended.*

Part 25 of the said Code recognizes the rights of minors:

> *Recognize the need to balance the developing competency of minors and the role of families in medical decision-making. Respect the autonomy of those minors who are authorized to consent to treatment.*

Part 28 & 29 provides provisions in respect to incompetent persons:

> *Respect the intentions of an incompetent patient as they were expressed (e.g., through a valid advance directive or proxy designation) before the patient became incompetent… When the intentions of an incompetent patient are*

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[127] 'Provinces and territories of Canada', http://en.wikipedia.org/wiki/Provinces_and_territories_of_Canada (Assessed 15 April 2009).

unknown and when no formal mechanism for making treatment decisions is in place, render such treatment as you believe to be in accordance with the patient's values or, if these are unknown, the patient's best interests.

The Ontario province in the Canadian jurisdiction has taken a different approach by incorporating the common law principle of consent to medical treatment into one statute. Provisions dealing with medical consent to treatment in general are reflected in the *Health Care Consent Act 1996* (Ontario). This Act came into effect in 1996 and has quite explicitly captured the important pillars of medical consent and its application. This Act contains provisions dealing with consent to treatment including 'elements of consent'[128], 'plan of treatment'[129], 'withdrawal of consent'[130], 'capacity to consent'[131], 'consent on incapable persons behalf'[132] and 'emergency treatment'[133]. Section 29 provides protection to the health care practitioner from liability. Furthermore the Consent and Capacity Board is formulated under Part 4 of the said Act and functions similar to a tribunal.

Section 7 of the Canadian Charter of Rights and Freedom stipulates that:

Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

The Charter is enshrined in the Constitution of Canada. 'The right to security of the person... consists of rights to privacy of the body and its health and of the right protecting the "psychological integrity" of an individual.'[134]

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[128] *Health Care Consent Act 1996* (Ontario) s 11.
[129] Above n 128, s13.
[130] Above n 128, s14.
[131] Above n 128, ss 15-19.
[132] Above n 128, ss 20-24.
[133] Above n 128, ss 25-28.
[134] 'Section Seven of the Canadian Charter of Rights and Freedom', http://en.wikipedia.org/wiki/Section_Seven_of_the_Canadian_Charter_of_Rights_and_Freedoms (Assessed 15 April 2009).

This right to security of the person was explained as applied to in a medical context in *Chaoulli v. Quebec (Attorney General)* [2005] 1 S.C.R. 791. The court held that 'Charter does not confer a freestanding constitutional right to health care, however, where the government puts in place a scheme to provide health care, that scheme must comply with the Charter.'[135] Furthermore, 'delays in medical treatment could have physical and stressful consequences'[136] and therefore contravenes section 7 of the Charter. However, there might be a case for extending this provision to cover situations of the patient in failure to warn cases.

(v) Fiji Jurisdiction

Fiji is a member of the World Medical Association (WMA) and adopts the WMA International Code of Medical Ethics. The Code was adopted by the 3rd General Assembly of the WMA in London, England in October 1949, and stipulates that:

> *A Physician shall respect the rights of the patient… and act only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient*

The 1997 Constitution of Fiji had provisions to safeguard and protect the interests of its citizens in the area of law concerning consent to medical treatment.

The *Constitution (Amendment) Act 1997* stipulates that:

> ***25.**-(2) Every person has the right to freedom from scientific or medical treatment or procedures without his or her informed consent or, if he or she is incapable of giving informed consent, without the informed consent of a lawful guardian.*

[135] Above n 134.
[136] Above n 134.

However, the Constitution of Fiji was abrogated by the President Ratu Josefa lloilo in April 2009. Therefore, constitutional redress cases pursuant to section 25 (2) will no longer be entertained by the courts in Fiji. However, civil claims pleaded in *negligence* on the issue of consent to medical treatment can still be initiated in the courts in Fiji.

Unlike the legislation in other jurisdictions, none of the Fiji legislation including *Mental Treatment Act* [Cap 113] and *Public Health Act* [Cap 111] reflects any provisions for laws concerning consent to medical treatment.

Tracing developments through ethical consideration to statutory application in the area of law concerning consent to medical treatment in various jurisdictions shows that special needs of people with mental disability and that of minors are taken into account under respective legislation.

It is clearly evident that provisions dealing with consent to medical treatment have either been reflected as part of legislation concerning Mental Health or as part of the guardianship scheme. 'In common law jurisdictions, legislatures operate under the assumption that statutes will be interpreted against the backdrop of the pre-existing common law.'[137]

2.2 International Treaties and Conventions

(i) Convention on the Protection of Human Rights and the Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine.

The *Convention on the Protection of Human Rights and the Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine* was issued by the Council of Europe, Oviedo, 4.IV. 1997.

[137] 'Common law', http://en.wikipedia.org/wiki/Common_law (Assessed 15 April 2009).

Article 5 of the said Convention states that:

> *An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it. This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks. The person concerned may freely withdraw consent at any time.*

'The explanatory report issued with the Convention espouses the view that patients should be able to give free and informed consent to medical treatment and states that the information provided to the patient should include relevant facts about the proposed treatment, the purpose, nature and consequences of the intervention, and the risks involved, including risks involved in alternative treatments and those related to the individual patient, such as age or the existence of other pathologies.'[138]

This view is similar in approach to the common law principles of disclosure in *Rogers v Whitaker* and has also been codified under the Mental Health legislation in New South Wales and Queensland. Furthermore, Article 5 of the said Convention emphasizes 'that requests for additional information be adequately answered'[139]. It also states that the person concerned has the right under this Article to freely withdraw his/her consent at any time.[140]

'Member states will only be bound by the Convention if and when they ratify it, and the guidance appears to go beyond the consent requirements in the present [United Kingdom] law, but it is evidence of a general drive towards patient autonomy in the developed world.'[141] The United States, Australia and Canada are recognized as signatories under Article 33 of the said Convention.

[138] 'Consent to medical treatment', http://www.mhra.gov.uk/Safetyinformation/Generalsafetyinformationandadvice/Product-specificinformationandadvice/Breastimplants/Siliconegelbreastimplants/IndependentReviewGroup-siliconegelbreastimplants/Consenttomedicaltreatment/index.htm (Assessed 7 January 2008).
[139] Above n 138
[140] Above n 138
[141] Above n 138

Part III: Consent to Medical Treatment and Information Disclosures

3.1 Introduction

This part focuses on the requirements for consent to avoid an action in *trespass* and the requirements for information disclosure to avoid an action in *negligence*. The doctrine of information disclosure to medical treatment is concerned with the provision of adequate advice to patients pertaining to the nature, risks and alternatives to treatments, on the basis of which the patient can make a sound decision about whether to consent to the medical treatment or on the contrary refuse any such treatment. The doctrine is very broad in application and has been applied over various jurisdictions accordingly. This doctrine plays a vital role in medico-legal discipline and has been applied in the form of either "true consent" or "informed consent".

Dr. SMA Babar in his academic paper on *True consent, informed consent and the English law*[142] noted:

> *True consent is a due process under which, the doctor explains to the patient, the nature of the treatment he intends to provide, and provides material information as would be provided by his peers in good standing, under the circumstances. He may withhold such information, as he would feel would be harmful to the patient to know (therapeutic privilege). The patient would then offer his agreement for this treatment. In short, the profession decides on what the patient needs to know.*
>
> *Informed consent, on the other hand, is a similar process to some extent but lays essential emphasis on what the patient would want to know, including about adverse effects, risks of failure, alternative choices and how that individual patient could be affected by the treatment or of its lack. Here, the patient decides on what he wants to know.*

[142] Above n 8.

This doctrine has been codified into health legislation in some jurisdictions, whereas the principles of common law are still applicable in other jurisdictions to safeguard and protect the rights of individuals in relation to making their own decision about the choice of medical treatment or procedure.

The statutory approach is taken into consideration when applying this doctrine in those jurisdictions that have statutory provisions embodied into their legislation. However, the common law principles of this doctrine are referred to in the absence of any such statutory provision.

This doctrine has been interpreted and applied differently in common law jurisdictions. In some jurisdictions an objective (reasonable person) approach is taken and in others a subjective (this particular person) approach has been adopted.[143] In the United Kingdom, the doctrine is applied in an objective manner whereby the approach taken pertains to the disclosure of significant risks by the physician to the individual concerned in the circumstances of the treatment or diagnosis.[144] The English law of consent to medical treatment rejects the principles of informed consent.

However 'in the [United States], Australian and Canadian jurisdictions, the doctrine takes into consideration both the objective and the subjective approach and requires that significant risks be disclosed, as well as those risks which would be of particular importance to that patient in that particular circumstances'[145]. The United States, Australian and Canadian law of consent is based upon the principles of informed consent.

Informed consent is well developed[146] in the United States. The principles of informed consent require that people about to undergo medical treatment be provided with all material information needed to make an informed decision. 'The determining factor as

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[143] 'Informed Consent', http://en.wikipedia.org/wiki/Informed_consent (Assessed 4 December 2008).
[144] Above n 143.
[145] Above n 143.
[146] Most States in the United States of America have enacted legislation to deal with informed consent.

to what risk are material is that of the "prudent patient"[147] rather than the doctor's assessment of what should be disclosed.'[148]

3.2 Contrary views regarding the extent of disclosure required

(i) English Jurisdiction

The doctrine of informed consent was rejected by the British courts in *Sidaway v Bethlem Royal Hospital Governors*.

Lord Diplock, Lord Keith and Lord Bridge in a majority judgment noted at 643:

> *On appeal the Court of Appeal upheld the judge, holding that the doctrine of informed consent based on full disclosure of all facts to the patient was not the appropriate test under English law.*
>
> *The test for liability in respect of a doctor's duty to warn his patient of risks inherent in treatment recommended by him was the same as the test applicable to diagnosis and treatment, namely that the doctor was required to act in accordance with a practice accepted at the time as proper by a responsible body of medical opinion. Accordingly, English law did not recognize the doctrine of informed consent.*

Lord Bridge indicated that the 'doctrine [of informed consent is] quite impractical in [its] application [since] it gives insufficient weight to the realities of the doctor/patient relationship'[149]. Furthermore Lord Bridge held that 'it seems quite unrealistic in any medical negligence action to confine the expert medical evidence to an explanation of the primary medical factors involved and to deny the court the benefit of evidence of medical opinion and practice on the particular issue of

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[147] This test was formulated in the United States case of *Canterbury v Spence* 464 F.2d 772

[148] Above n 8.

[149] Above n 33, 662.

disclosure'[150]. Lord Bridge on the question of disclosure held that the 'degree of disclosure of risks is best calculated to assist a particular patient to make a rationale choice whether or not to undergo a particular treatment must primarily be a matter of clinical judgment'[151].

Lord Diplock in agreement held that 'there is no room in the concept of informed consent for the "objective" patient to whom the doctor is entitled, without making any inquiry whether it is the fact or not, to attribute knowledge of some risks but not of others'[152]. Lord Diplock on the question of disclosure held that 'to decide what risks the existence of which a patient should be voluntarily warned and the terms in which such warning, if any, should be given, having regard to the effect that the warning may have, is much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care to the individual patient, and expert medical evidence on this matter should be treated the same'[153].

Lord Scarman in a dissenting judgment noted at 649:

> *The doctrine of informed consent amounts to where there is a 'real' or a 'material' risk inherent in the proposed operation (however competently and skillfully performed) the question whether and to what extent a patient should be warned before he gives his consent is to be answered not by reference to medical practice but by accepting as a matter of law that, subject to all proper exceptions (of which the court, not the profession, is the judge), a patient has a right to be informed of the risks inherent in the treatment which is proposed.*

Lord Scarman's view was that 'the profession should not judge its own cause'[154] and the question of disclosure must be answered not by reference to medical practice but

[150] Above n 33, 662.
[151] Above n 33, 662-663.
[152] Above n 33, 658.
[153] Above n 33, 659.
[154] Above n 33, 649.

subject to a patient's right to be informed of the risks inherent in the proposed treatment.[155]

The increasing number of claims in failure to warn cases has prompted the "General Medical Council" (GMC) to adapt to the practice of disclosing significant risks as well as those risks which are important to the patient in the circumstances of treatment or diagnosis. The GMC guideline on *Consent: patients and doctors making decision together*[156] came into effect on 2nd June 2008. Provision 8 of this guideline prohibits doctors from making assumptions about the information a patient might want or need and the clinical or other factors a patient might consider significant. However, the English law of consent to medical treatment still favors the view that the doctor must weigh the risks and inform the patient of the significant risks inherent in the proposed treatment.

The *Mental Health Act 2007* (UK) does not contain any specific provision outlining the requirements of consent to medical treatment or the extent of disclosure required.

From the analysis of the above law, it is evident in the English jurisdiction that there has been a transition away from the doctrine of informed consent.

(ii) Australia Jurisdiction

The Australian jurisdiction has applied the doctrine of informed consent following the decision in *Rogers v Whitaker*. However, 'in *Rogers v Whitaker* this court did not explain the duty to warn in terms of "informed consent", because it was there concerned with a cause of action framed in negligence, not trespass' [and] "consent" (or lack of it) was not, as such, a defence'[157]. 'Nevertheless, there is no doubt that the rule that the Court expressed in *Rogers v*

[155] Above n 33, 649.
[156] 'Consent: patients and doctors making decision together' (2008) http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance/Consent_guidance.pdf (Assessed 28 April 2009)
[157] Above n 102, 476.

Whitaker was addressed to the concerns that are commonly dealt with, in legal and medical literature, as relevant to securing the "informed consent" of a patient to invasive treatment.'[158]

Mason CJ, Brennan, Dawson, Toohey and McHugh JJ in a joint judgment noted at 489-490:

> *In legal terms, the patient's consent to the treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended.*
>
> *The law should recognize 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 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 risk, would be likely to attach significance to it.*

This principle was applied in the failure to warn case of *Chappel v Hart*.

Justice Gummow in a majority judgment noted at 533:

> *In the present case, the primarily judge held that Dr Chappel had breached the duty to warn of a material risk, which is formulated in Rogers v Whitaker and which, in the circumstances of the case, Dr Chappel had owed to his patient.*

Further application of this principle was noted in the failure to warn case of *Rosenberg v Percival.*

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[158] Above n 102, 476-477.

Justice Gummow in a majority judgment noted at 458-460:

> *Under the Rogers test… a risk is material if: (1) in the circumstances of the case, a reasonable person in the patient's position would be likely to attach significance to it (objective limb); or (2) the medical practitioner was, or should have been, aware that the particular patient would be likely to attach significance to it (the subjective limb).*
>
> *Both Rogers and Chappel v Hart were concerned with the subjective limb; in this case, it is the objective limb… Therefore, the test of whether the risk was material falls to be determined be reference to the first, or objective limb and thus to the reasonable person in the patient's position. From the findings of fact made at trial, the relevant factors to consider include: the temporary nature of any potential harm; the possibility of some pain, but not severe pain; the 10 percent chance of such complications arising; the fact that the respondent was concerned about her malocclusion, she wanted the "best result" and the osteotomy was the most effective way to remedy the problem; the respondent was an experienced and knowledgeable nurse who was certainly aware that all surgery carried some risk and the fact that the respondent had received advice from a number of sources indicating that she should proceed with the treatment. In light of these factors, it was open to the trial judge to conclude that a reasonable person in the respondent's position would not, in the sense of Rogers, be "likely to attach significance to" the risk. Therefore the risk was not a material risk.*

From the analysis of the above cases, it is evident in the Australian jurisdiction that there has been acceptance to the doctrine of informed consent. However, the courts in explaining the duty to warn of risks to treatments have not used the actual terminology "informed consent". The reason for this being that "informed consent" is a term used for action in *trespass*. This principle was applied in the

failure to warn cases of *Rogers v Whitaker* and *Chappel v Hart*. *Rogers v Whitaker* formulated a two tier test for materiality. A risk is material if: (1) in the circumstances of the case, a reasonable person in the patient's position would be likely to attach significance to it (objective limb); or (2) the medical practitioner was, or should have been, aware that the particular patient would be likely to attach significance to it (the subjective limb). A similarity between *Rogers v Whitaker* and *Chappel v Hart* is that they both were concerned with the subjective limb. A possible distinction between the two cases is that *Rogers v Whitaker* was based on the issue of materiality whereas *Chappel v Hart* was based on the issue of causation. This principle was applied in the failure to warn case of *Rosenberg v Percival*. However, *Rosenberg v Percival* was concerned with the objective limb. Nevertheless, the Australian jurisdiction has applied the principles of "informed consent" to failure to warn cases.

Reginald S.A. Lord in an article on *Informed Consent in Australia*[159] noted:

> *Informed consent is an agreement to a proposed invasive procedure, given after proper and sufficient explanation of the condition, the procedure, the general and specific risks, the benefits and anticipated outcomes, alternative treatment available, the risk of not having the procedure. True consent to what happens to oneself provides an opportunity to evaluate comprehensively the options available and their associated risks. Questions must be answered truthfully and the patient, not the Medical Practitioner makes the final decision. To assist a patient to make an informed choice, it is essential that the Medical Officer has some knowledge of therapeutic alternatives and their associated risks.*

Reginald S.A Lord in this article outlines the principles of "informed consent" which are similar to the principles as stated in *Rogers v Whitaker*.

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[159] Reginald S.A. Lord, 'Informed Consent in Australia', (1995) *Australian New Zealand Journal of Surgery* 65 (4). 224-228.

The AMA Code of Ethics, Part 1.1 (y) also encourages the doctors to adhere to and apply this principle to medical treatment:

> *Protect the right of doctors to prescribe, and any patient to receive, any new treatment, the demonstrated safety and efficacy of which offer hope of saving life, re-establishing health or alleviating suffering. In all such cases, fully inform the patient about the treatment, including the new or unorthodox nature of the treatment, where applicable.*

In some Australian States, the provisions on "informed consent" as outlined in the presiding cases and Codes of Ethics have been included in the statutory provision.

In New South Wales, section 91 of the *Mental Health Act 2007* (NSW) in relation to ECT stipulates that:

> *(1) A person is taken to have given informed consent to the administration of electro convulsive therapy if the person gives a free, voluntary and written consent after this section is complied with.*
>
> *(2) The following steps must be taken before consent is obtained:*
>
> *(a) a fair explanation must be made to the person of the techniques or procedures to be followed, including an identification and explanation of any technique or procedure about which there is not sufficient data to recommend it as recognized treatment or to reliably predict the outcome of its performance,*
>
> *(b) a full description must be given, without exaggeration or concealment, to the person of any possible discomforts and risks of the treatment (including possible loss of memory),*
>
> *(c) a full description must be given to the person of any expected benefits of the treatment,*

(d) a full disclosure must be made, without exaggeration or concealment, to the person of any appropriate alternative treatments that would be advantageous to the person,

(e) an offer must be made to the person to answer any inquiries concerning the procedures or any part of them,

(f) the person must be given notice that the person is free to refuse or to withdraw consent and to discontinue the procedures or any part of them at any time,

(g) a full disclosure must be made to the person of any financial relationship between the person proposing the administration of the treatment or the administering medical practitioner, or both, and the facility in which it is proposed to administer the treatment,

(h) the person must be given notice of their right to obtain legal and medical advice and to be represented before giving consent,

(i) any question relating to the techniques or procedures to be followed that is asked by the person must have been answered and the answers must appear to have been understood by the person,

(j) a form setting out the steps in this subsection is to be given to the person and an oral explanation of the matters dealt with in the form is to be given to the person in a language with which the person is familiar.

In Queensland, section 137 of the *Mental Health Act 2000* (Qld) in relation to ECT stipulates that*:*

Before a person gives informed consent, a full explanation must be given to the person in a form and language able to be understood by the person about-

(a) the purpose, method, likely duration and expected benefit of the treatment; and

> *(b) possible pain, discomforts, risks and side effects associated with the treatment; and*
>
> *(c) alternative methods of treatment available to the person.*

It is important to note that these statutory provisions only apply to ECT and not to any other treatments under their respective legislation.

In South Australian *Consent to Medical Treatment and Palliative Care Act 1995* (SA)[160] has been enacted to deal with issues regarding consent to medical treatment. This Act is broader than the New South Wales and Queensland Mental Health legislation. However, this Act does not provide a statutory definition of consent, medical consent or informed consent for that matter.

From the analysis of the above law, it is evident that the Australian Common Law has applied the doctrine of informed consent throughout the cases however the statutory application has only been applied to special circumstances such as ECT.

3.3 The Purpose of Consent to Medical Treatment

'Consent is a fundamental tenet of medical law.'[161] 'It is the guardian of autonomy; the protector against unwelcome intrusion.'[162] 'The basic rule is simple; no one has the right to touch anyone else without lawful excuse [and] to do so may amount [to a claim in *trespass*] and/or *negligence*'.[163] Therefore, the main purpose of taking consent is to protect the patient.

In *Re W* (a minor) (medical treatment) [1992] 4 All ER 627, Lord Donaldson MR in a majority judgment noted at 633-634:

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[160] This Act has been amended by the *Medical Treatment and Palliative Care* (Prescribed Forms) *Amendment Act 2004* (SA) and the relevant provisions of this Act are stated in 2.1 and 3.4.

[161] 'The Theory of Consent', (2002) http://www.dentalgain.org/consent.html (Assessed 6 November 2008)

[162] Above n 161.

[163] Above n 161.

> *There seems to be some confusion in the minds of some as to the purpose of seeking consent from a patient (whether adult or child) or from someone with authority to give that consent on behalf of the patient. It has two purposes, the one clinical and the other legal.*
>
> *The clinical purpose stems from the fact that in many instances the co-operation of the patient and the patient's faith or at least confidence in the efficacy of the treatment is a major factor contributing to the treatment's success. Failure to obtain such consent will not only deprive the patient and the medical staff of this advantage, but will usually make it much more difficult to administer the treatment.*
>
> *The legal purpose is quite different. It is to provide those concerned in the treatment with a defence to a criminal charge of assault or battery or a civil claim for damages for trespass to the person. It does not, however, provide them with a defence to a claim that they have negligently advised a particular treatment or negligent carried it out.*

Lord Donaldson's view was that the process of taking consent to medical treatment boosts the confidence of the patients in regards to the effectiveness of the treatment. This in turn contributes to the success of that treatment.[164] However, the legal purpose provides a defence in *trespass* only and does not extend to claims arising in *negligence*.

'The common law purpose of the doctrine of consent [to medical treatment] is to provide a framework for justifying necessary medical treatment rather than to enforce a requirement that proper information be given to the patient, which is the realm of the duty of care and the cause of action [in] negligence.'[165] Taking consent shows that the doctor respects the dignity and independence of the patient. It ensures that the patient is protected from unwanted treatments. It provides the patient with the opportunity to

[164] *Re W* (a minor) (medical treatment) [1992] 4 All ER 627 at 633.
[165] Above n 8.

contribute to his/her treatment plan and builds up the bond of trust in the doctor-patient relationship.

3.4 The Statutory Age of Consent to Medical Treatment[166]

The statutory age of consent to medical treatment is the age at which a person is deemed to be competent to give consent to any medical treatment or procedure.[167] This age of consent to medical treatment has been embodied in the statutes within their respective jurisdictions and accordingly the actual age of consent stipulated therein is 16yrs or above.

In South Australia, section 6 of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) stipulates that:

> *A person of or over 16 years of age may make decisions about his or her own medical treatment as validly and effectively as an adult.*

In the New Zealand Jurisdiction, section 87 of the *Mental* Health *(Compulsory Assessment and Treatment) Act 1992* stipulates that:

> *Notwithstanding anything in section 36 of the Care of Children Act 2004 or any other enactment or rule of law to the contrary, in respect of a patient who has attained the age of 16 years, the consent of a parent or guardian to any assessment or treatment for mental disorder shall not be sufficient consent for the purposes of this Act.*[168]

In the Ontario province of the Canadian Jurisdiction, section 20 (2) of the *Health Care Consent Act 1996* (Ontario) stipulates that:

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[166] The common law position concerning minors is dealt with at 3.121 (ii) Minors
[167] 'Age of Consent', http://www.conservapedia.com/Age_of_consent (Assessed 26 August 2008)
[168] Section 87 was amended, as from 1 July 2005, by section 151 *Care of Children Act 2004* (2004 No 90) substituting the words "section 36 of the *Care of Children Act 2004*" for the words "section 25 of the *Guardianship Act 1968*".

A person described in subsection (1) may give or refuse consent only if he or she,

(a) is capable with respect to the treatment;

(b) is atleast 16 years old, unless he or she is the incapable person's parent.

In the Fiji jurisdiction, there is no statutory provision specifying the age of consent to medical treatment. However, the *Interpretation Act* [Cap 7] defines an infant or minor as a person under 21 years of age. Whereas, Section 46 (1) of the *Family Law Act 2003* stipulates that each of the parents of a child who is under 18 years has parental responsibility for the child. Accordingly, the parental responsibility terminates when the child reaches the age of 18 and therefore the child is able to consent to his/her choice of medical treatment. Fiji is a signatory to the *United Nations Convention on the Rights of the Child* which states that a child is someone who has NOT attained the age of 18 years. Therefore, the position in Fiji is that a competent person 18 years or above is capable of deciding whether to give consent or refuse to give consent to the medical treatment.

From the analysis of the above statutes, it is evident in South Australia, New Zealand and the Ontario province of Canada that the actual age at which a competent person can provide consent to undergo a medical treatment or procedure is 16 years or above.

3.5 How long is Consent Valid for?

There is no statutory defined period over which consent once given remains valid.[169] It is important to take into consideration whether the position of the patient whilst consenting will still remain the same over a period of time. 'Consent is useful for as long as [the person giving consent] is able to recall the comprehensive information required for an informed consent and as long as there has been no significant change in [the] health status [of the patient].'[170]

[169] 'Calvary Health Care ACT Consent Policy', (2004) http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1102985419&sid (Assessed 10 November 2008)

[170] 'Queensland Health Policy Statement: Informed Consent for Invasive Procedures', http://www.health.qld.gov.au/informedconsent/ConsentForms/14025.pdf (Assessed 10 November 2008)

In the Australian jurisdiction, the Queensland Health Quality Improvement and Enhancement Program (QEHPS) formulated the policy on *Informed Consent to Invasive Procedures*[171] which states that:

> *Due to the possibility of long surgical waiting times and/ or risks that may have changed over time, the consent is only considered valid for a period of twelve months. A new consent must be obtained if the patient/ parent/ guardian (if a child)/ substitute decision-maker is unable to recall the information.*

In the Australian Capital Territory (ACT), *Calvary Health Care Consent Policy 2004*[172] also states that:

> *A 12-month period represents the upper limit of acceptability over which consent remains valid*

According to the said policy, the following factors need to be taken into consideration if the period of validity is in question:

> *The gravity of the decision, has the procedure or alternative means of treatment changed since consent was granted, the Individual circumstances, eg. Youth, age; and any general change in the patient's condition since the provision of consent.*

There is no policy in regards to how long consent is valid upon provision in Fiji.

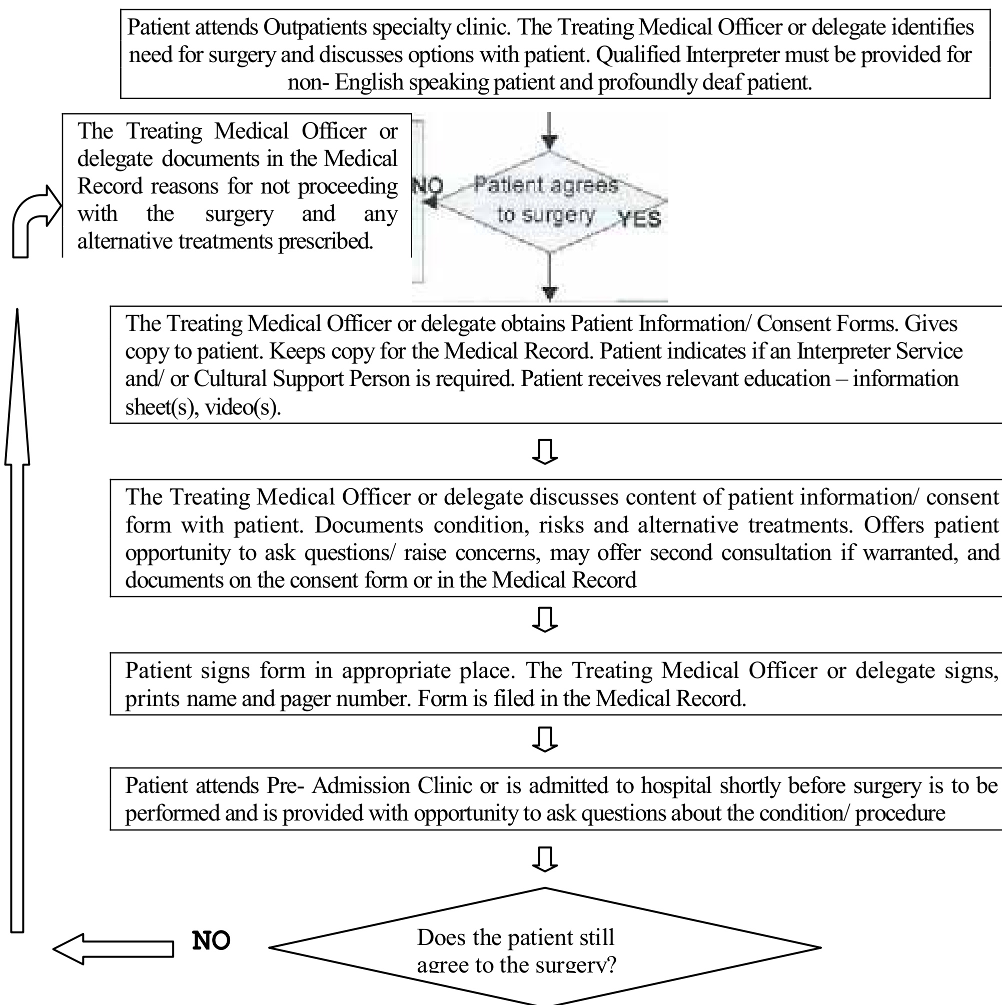
It is submitted that there must be time limitation imposed to ensure that provision of consent to medical treatment once given specifies a timeframe that it remains valid for. I agree with the above policies in which a period of 12 months is specified. However, in any event it is of essence that the doctor re-accesses the patient's recollection of the information in relation to the nature, risks and alternatives to the proposed treatment before proceeding with any such treatment.

[171] Above n 170.
[172] Above n 169.

3.6 Obtaining Consent to Medical Treatment[173]

Consent to carry out any medical treatment or procedure on an individual must 'be obtained from the patient/ parent/ guardian [or] substitute decision-maker as soon as possible after the need for a procedure or treatment has been identified'.[174] The QHEPS policy on *Informed Consent for Invasive Procedure*[175] outlines the process for obtaining consent to medical treatment as follows:

THE PROCESS FOR OBTAINING CONSENT[176]

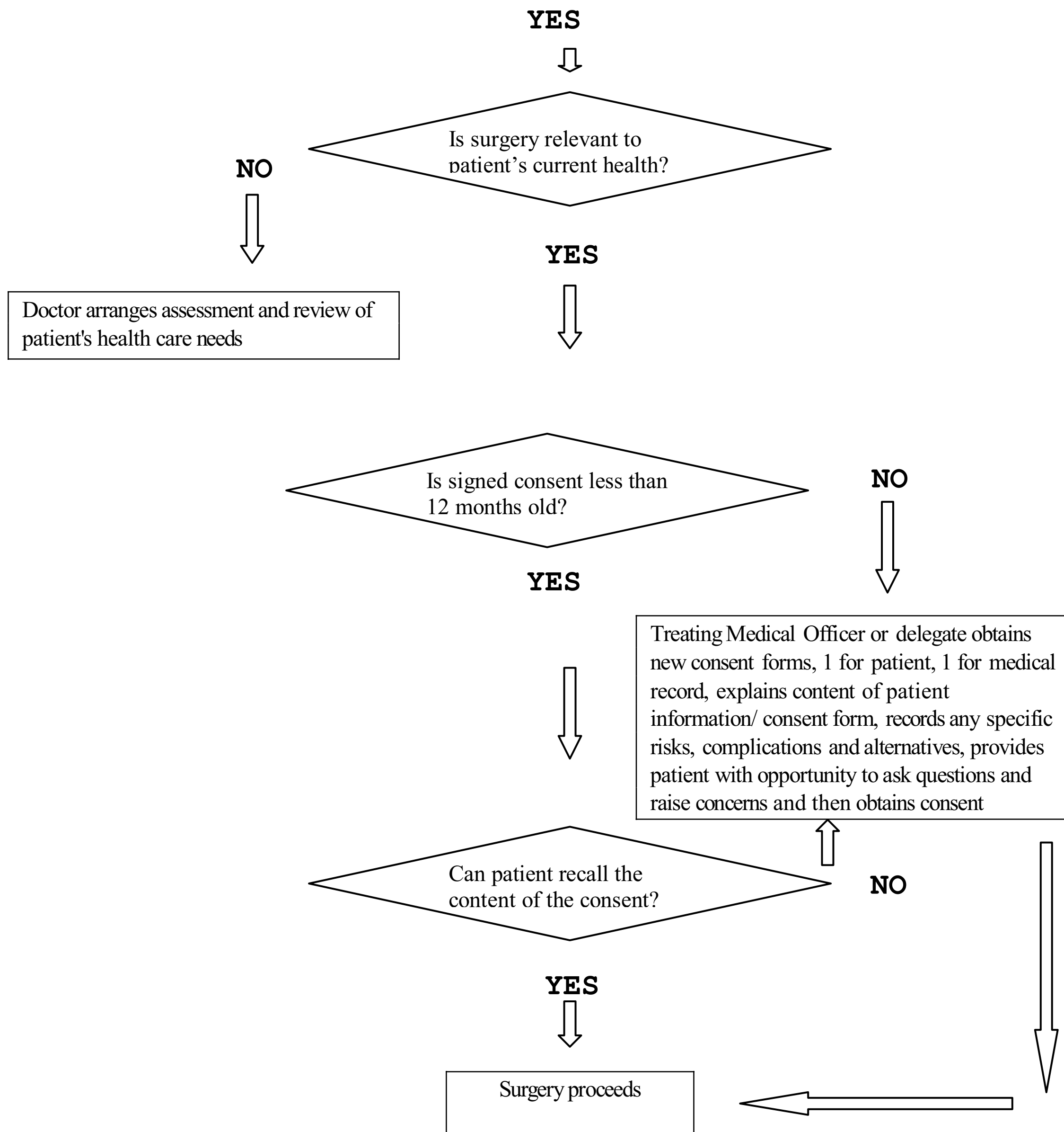


[173] The standard of disclosure required is discussed in 3.2. Discussion of consent in relation to minors can be found at 3.121 (ii) Minors

[174] Above n 170.

[175] Above n 170.

[176] Above n 170.



The above flowchart diagram depicts that the treating doctor or the delegate medical practitioner must explain to the patient about the nature, risks and alternatives of the proposed medical treatment. The patient must be provided with the opportunity to ask questions/ raise concerns and even offered a second consultation if warranted. The content of the consent form must be explained to the patient and the discussions taken between the doctor and the patient must be documented on that form or in the medical record. The consent form must be executed by the patient and the doctor. Furthermore, it is important to re-access whether the patient can recall the information in relation to the

nature, risks and alternatives of the proposed medical treatment before proceeding with any such treatment. In the circumstances, the patient is unable to recall the content of the consent then the patient must be explained again about the nature, risks and alternatives of the proposed medical treatment and consent form executed accordingly, before proceeding with the treatment.

The said policy in relation to disclosure of information states that:

> *The patient/ parent/ guardian (if a child)/ substitute decision-maker must be advised in lay terms about the: -*
>
> - *Diagnosis;*
> - *Recommended treatment;*
> - *Material risks*[177] *in percentage terms associated with:*
>   - *The recommended treatment;*
>   - *Alternative treatment options;*
>   - *The no treatment options,*
>
> *in so far as a reasonable person would expect to be advised of significant risks.*

This particular provision of the said policy is similar to the principles of disclosure as formulated in *Rogers v Whitaker*.[178]

In New Zealand, Right 5 of the *Code of Health and Disability Services Consumers Rights 1996* states that:

> *Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.*

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[177] 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 be reasonably aware, that the particular patient, if warned of the risk, would be likely to attach significance to it. This test is formulated in *Rogers v Whitaker* and discussed in 3.2.

[178] This principle of disclosing "material risks" is discussed in 3.2.

> *Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.*

In the United Kingdom, Provision 9 of the GMC guidelines on *Consent: patients and doctors making decisions together*[179] states that the information which patients want or ought to know, before deciding whether to consent to medical treatment, may include:

> a. *the diagnosis and prognosis;*
> b. *any uncertainties about the diagnosis or prognosis, including options for further investigations;*
> c. *options for treating or managing the condition, including the option not to treat;*
> d. *the purpose of any proposed investigation or treatment and what it will involve;*
> e. *the potential benefits, risks and burdens, and the likelihood of success, for each option; this should include information, if available, about whether the benefits or risks are affected by which organisation or doctor is chosen to provide care;*
> f. *whether a proposed investigation or treatment is part of a research programme or is an innovative treatment designed specifically for their benefit;*
> g. *the people who will be mainly responsible for and involved in their care, what their roles are, and to what extent students may be involved;*
> h. *their right to refuse to take part in teaching or research;*
> i. *their right to seek a second opinion;*
> j. *any bills they will have to pay;*
> k. *any conflicts of interest that you, or your organisation, may have;*
> l. *any treatments that you believe have greater potential benefit for the patient than those you or your organisation can offer.*

[179] Above n 156.

In brief, Provision 9 of this policy indicates that GMC have set the standard of disclosure by doctors based on the principles formulated by the dissenting judgment of Lord Scarman in *Sidaway v Bethlem Royal Hospital Governers* which was later applied in *Roger v Whitaker*.[180]

In the Fiji jurisdiction, there is no written policy in regards to consent to medical treatment. However the customary practice of taking consent is based on the principles of the English law[181]. The doctor only provides that information which the patient might attach significance to and the patient is given the opportunity to make the choice about the proposed treatment or procedure. The details in relation to the provision of consent to medical treatment are noted in a consent form. This practice has been adapted in the major hospitals at Colonial War Memorial Hospital, Labasa Hospital and Lautoka Hospital. However, the customary practice of taking consent to medical treatment is still lacking in its application in the rural Health Centers and Hospitals. The fact that most of the people in the rural areas are poor and uneducated contributes to this down side of obtaining consent.[182]

3.7 Consent Forms

In the Australian jurisdiction, 'QHEPS has developed an *Informed Consent Program* (ICP) for production and audit of documentation that supports the informed consent process for patients undergoing elective surgery'.[183] 'The ICP has developed procedure-specific consent forms for those invasive procedures considered to be of highest risk':[184]

1. Anaesthetic
2. Bowel surgery for tumors
3. Lumpectomy (removal of lump) and mastectomy (removal of breast)

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[180] This principle has been discussed in detail at 3.2.
[181] The English law principles are discussed in detail at 3.2.
[182] The cultural and social factors in relation to consent to medical treatment in Fiji are discussed in detail at 1.1322 (iii) Fiji Courts
[183] Above n 170.
[184] Above n 170.

4. Colonoscopy
5. Hysterectomy
6. Inguinal Hernia Repair – open and laparoscopic
7. Laparoscopic cholecystectomy
8. Female sterilisation
9. Prostatectomy – open and TURP
10. Total hip replacement
11. Total knee replacement

'ICP has also developed generic consent forms which include sections for information on condition, the procedure and the risk and significant risks.'[185] This generic consent form is used to obtain consent for procedures which does not fall within the ambit of specific invasive treatment or procedures.

The QHEPS policy on *Informed Consent for Invasive Procedure*[186] states that:

> *The name, signature and title of the treating Medical Practitioner obtaining the patient/ parent/ guardian (if a child)/ substitute decision-maker's consent is to be recorded on the consent form or in the patient's record as applicable*
>
> *Details of any further documentation provided to aid in the consent process pertaining to procedures must be recorded in the patient's medical record.*

'The executed consent form is important since it contains valuable evidence of the communication process used to obtain patient/ parent/ guardian (if a child)/ substitute decision-maker's consent.'[187]

Documenting consent also provides valid evidence that all material risks have been disclosed by the doctor to the patient, what information was disclosed, who was the

[185] Above n 170.
[186] Above n 170.
[187] Above n 170.

doctor taking consent, from whom consent was taken, what was the nature of the consent and thus these information can be used in court proceedings to aid in the defence of any medical negligence matter instituted by the patient against the doctor.

It is vital that what is written in the consent form reflects what is agreed in principle by the patient. The details in relation to the scope of consent to medical treatment that was initially given, was discussed in the English case of *Davis v Barking, Havering and Brentwood HA* [1993] 4 Med LR 85.

The facts of the case are as follows:[188]

> The patient had an operation for the removal of a cyst. She signed a consent form in which it was stated that she consented to the 'administration of general, local or other anaesthetics'. She was informed that a general anaesthetic would be used. However, during the procedure, in addition to this, a caudal block was given. The claimant temporarily lost movement over her legs and control of bladder and claimed that the anaesthetist had administered the caudal block without her consent.

Justice McCullough noted at 91:[189]

> *It would be wrong to sectionalize what the claimant consented to. There were not two separate operations, which had been performed for which consent to each would have been necessary. The correct question was 'Have the defendants shown that the claimant consented to a procedure the nature and effect of which had in broad terms been explained to her?'*

Justice McCullough 'held that the claimant had understood in "broad terms" the nature of what was to be done to her, namely that she would receive an anaesthetic'[190]. 'The

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[188] Grubb A & Laing J, 'Principles of Medical Law' (2nd ed, 2004) at 155.
[189] Above n 188.
[190] Above n 188.

judge did not rely upon the broadly drafted terms of the consent form'[191] and concluded 'that viewed "in the round" the caudal block was "part and parcel"' of the anaesthetic she had (with knowledge) agreed to.'[192]

In the Canadian jurisdiction, the terms incorporated in the consent form was taken into consideration to ascertain whether the particular treatment falls within the scope of the consent that was given, in the case of *Pridham v Nash* (1986) 33 DLR (4th) 304.

The facts of the case are as follows:[193]

> The patient was suffering from periodic pain in the pelvic region and underwent a laparoscopy to determine its cause. The patient agreed to the procedure and signed a consent form, which stated that she also consents to additional or alternative procedures as may be necessary or medically advisable during the course of such procedure. The doctor during the laparoscopy found adhesions between her pelvis and abdominal wall. The doctor divided the adhesions using a forceps. The patient developed complications including inflammation of the peritoneum due to the adhesion procedure. The patient claimed that she had only consented to the investigatory procedure and she had not consented to the adhesion procedure.

Justice Holland in a single judgment noted at 308-309:

> *If the laparoscopic examination, an investigative procedure, had revealed a major problem requiring surgery then, in my view, the surgeon would not be entitled to rely on the original consent and the general words of the consent… to carry out the major surgery. The surgeon would have been required to consult further with the patient and obtain a further consent to the major operation. However, this case, in my view, is different.*

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[191] Above n 188.
[192] Above n 188.
[193] *Pridham v Nash* (1986) 33 DLR (4th) 304.

> *From a practical point of view it would have been foolish for Dr. Nash to wait for Mrs Pridham to come out of the anaesthetic and then seek her consent to go through the same incision again to cut the two adhesions. The additional curative surgery was of such a minor nature that it falls practically in the same category as taking a sample for biopsy.*
>
> *In my opinion what happened here came within the wording of the consent and there was, therefore, express consent to this surgery.*

Justice Holland relied upon the wordings of the clause in the consent form and held that the particular clause does not extent to cover major surgery. However, minor surgery can fall within the scope of this consent clause.

The factors which should be taken into consideration when determining the scope of consent to medical treatment that was initially given, was discussed in the Canadian case of *Brushnett v Cowan* (1990) 69 DLR (4th) 743.

The facts of the case are as follows:[194]

> The patient had a palpable lump on a right thigh that was associated with an injury she had sustained to her right leg. The patient underwent a muscle biopsy. The patient agreed to the procedure and signed a consent form, which stated that she also consents to such further or alternative measures as may be found to be necessary during the course of the operation. During the operation, the defendant carried out a bone biopsy as well as the muscle biopsy. The patient claimed that she had only consented to the investigatory procedure and she had not consented to the bone biopsy.

J.A. Marshall in a majority judgment noted at 751-753:

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[194] *Brushnett v Cowan* (1990) 69 DLR (4th) 743.

> *Therefore, all relevant circumstances leading up to the surgery should be considered when determining what the patient agreed to when he or she submitted to the procedure. Any written consent will bear obvious weight upon such an assessment.*
>
> *Considered from that perspective of the circumstances, the authorization in the second paragraph consenting "… to such further or alternative measures as may be found to be necessary during the course of the operation or special procedure…" may be construed, in my opinion, as consenting to the removal of a necessary sample of the bone adjacent to the muscle in pursuit of the continuing investigative process.*
>
> *Considering all of these circumstances, I am of the opinion that the bone biopsy performed upon Miss Brushett by Dr. Cowan did not go beyond the consent given by her to him.*

J.A Marshall indicated that 'the full extent of [the consent that was initially provided] must be gained by looking at all of the circumstances arising from the [doctor-patient relationship], against the background of which the formal consent will be viewed'[195]

In the Fiji jurisdiction, there is no written policy formulated in regards to consent forms. However, consent forms are used in the major hospitals[196]. The consent form is similar to the English and Canadian jurisdiction to the extent that it also contains the clause 'I also consent to such further or alternative operative measures as may be found to be necessary during the course of the operation and to the administration of a local or other anaesthetic for any provision'[197]. There is a separate consent form for surgery which also incorporates the above clause and states that 'the doctor has also told me that an

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[195] Above n 194, 753.
[196] The major hospitals in Fiji are: Colonial War Memorial Hospital, Labasa Hospital and Lautoka Hospital.
[197] This clause was also present in the consent form that was the subject of the discussion in the English case of *Davis v Barking, Havering and Brentwood* and the Canadian case of *Pridham v Nash* and *Brushnett v Cowan*. See Appendix 3 & 4 for the consent forms that are used in Fiji.

anaesthetic, medicine or blood transfusion may be needed, and these may have some risks; additional procedures or treatments may be needed if the doctor finds something unexpected and complications may occur'[198].

From the analysis of the above cases, it is evident that the circumstances leading up to the signing of the consent form must be taken into consideration in determining the scope of that consent. 'Thus, the procedure complained of in [the Canadian cases of *Pridham v Nash* and *Brushnett v Cowan*] fell, as in *Davis v Barking, Havering and Brentwood*, within the scope of what the patient had understood she had given consent for.'[199] A possible distinction is that the English case of *Davis v Barking, Havering and Brentwood* did not rely upon the drafted terms of the consent form whereas the Canadian cases *Pridham v Nash* and *Brushnett v Cowan* relied upon the terms of the consent form together with the circumstances surrounding the signing of the form, in determining the scope of that consent.

It is submitted that the treating doctor or the specialist-in-charge must take the role of explaining to the patient in relation to the procedure, risks and alternatives of the proposed treatment. This role under no circumstances must be delegated to the junior/assisting doctors or nurses. The reason being that the patient has formed a bond of trust with the treating doctor or the specialist-in-charge and thus will be able to communicate any doubts and raise questions in that regards with the doctor he/she trusts. This transition also shows that the doctor respects the wishes of the patient and boosts the confidence of the patient in the efficacy of the treatment. Secondly, the consent formed must be signed by the patient in the circumstances when he/she is able to make his/her own decision about the proposed treatment. This decision must be made on the basis of the information that is provided by the doctor and the patient is able to understand and weigh the balance of that information.

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[198] See Appendix 4 for the consent form for surgery used in Fiji.
[199] Above n 188, 156.

3.8 Elements of a valid Consent

In the Australian jurisdiction, the New South Wales Office of the Public Guardian has formulated a policy on *determining whether to consent to proposed medical or dental treatment*[200]. This policy includes provisions on elements of a valid consent.

The said policy states that consent to medical treatment is valid, if the following elements are fulfilled:[201]

1. *Capacity - the person must be able to 'understand and appreciate the general nature and consequences of the procedure/treatment'*[202]*. The person must also be able to communicate with consistency, but not necessarily verbally, that they are providing or withholding their consent.*
2. *Volition - the consent must be freely given and the person must not be pressured into providing consent.*[203]
3. *Adequate information - the practitioner must provide sufficient information to the patient to enable him/her to come to a 'reasoned decision'*[204].
4. *Specificity - the consent given by the person must be specific to the particular treatment proposed.*

The Ontario province in the Canadian jurisdiction has statutory provisions in the *Health Care Consent Act 1996* (Ontario) to deal with issues concerning valid consent.

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[200] 'Determining whether to consent to proposed medical or dental treatment', (2007) http://www.dadhc.nsw.gov.au/NR/rdonlyres/C21BABCF-6001-400F-9D38-E4042FAD6281/3025/HealthCarePolicyandProceduresAtt4PublicGuardiancon.pdf (Assessed 10 November 2008).
[201] Above n 200.
[202] This rule is discussed in 3.12. The exceptions to this general rule include: application of the doctrine of necessity, urgent treatment required to save a person's life, or to prevent serious damage to their health, or to prevent or alleviate significant pain or distress; treatments authorized by statute; therapeutic privilege or waiver by patient. These exceptions are discussed in 3.10.
[203] This can vitiate the consent that was provided. The factors contributing to vitiating consent is discussed in 3.11.
[204] The duty a doctor owes to his/her patient in relation to the disclosure of material risks (relevant to that particular person) is discussed in the judgment of the High Court of Australia in *Rogers v. Whitaker*. This is discussed in 3.2

Section 11 (1) of the said Act stipulates that:

The following are the elements required for consent to treatment:

1. *The consent must relate to the treatment.*
2. *The consent must be informed.*
3. *The consent must be given voluntarily.*
4. *The consent must not be obtained through misrepresentation or fraud.*

It is of essence that in order for consent to be valid, 'the consent needs to be provided by a competent person[205], that the person must be adequately informed about the nature of what he/she is agreeing to and that the person should be acting voluntarily and not under the undue influence of another'[206].

Unlike the Canadian jurisdiction, there are no statutory provisions regarding elements of consent in the United Kingdom, Australia, New Zealand and Fiji jurisdictions.[207]

3.9 Express and Implied Consent

Consent to medical treatment must be obtained before proceeding with the treatment or procedure and this consent must be in writing. However, in certain circumstances, this consent may be expressed or implied.

Andrew Grubb and Judith Laing in their book on *Principles of Medical Law*[208] noted at 148:

Express consent is either verbal or written. Verbal consent is difficult to prove; therefore, most surgical procedures require written consent.

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[205] This is discussed in 3.2.
[206] Above n 188, 134.
[207] The common law position in relation to capacity is discussed in 3.12.
[208] Above n 188.

> *Implied consent can be inferred or presumed. Consent is implied when competent adults willingly submit to procedures (eg, an individual who stands in line to receive an immunization and willingly accepts the procedure when his or her turn comes). Consent is presumed in life-threatening medical emergencies.*

'A valid legal consent is given even where the patient does not demonstrate his agreement providing that the state of his mind was, in fact, that he agreed. In other words, an unexpressed actual consent is, in law, a valid consent.[209]

'Where the patient conducts himself as such that it is reasonable to imply that he consented to the treatment or procedure, the law merely prohibits the patient because of his conduct from denying that he consented even though, in fact, he did not.'[210] This principle was demonstrated in the United States case of *O'Brien v Cunnard SS Co* (1891) 28 NE 266 (Mass Sup Jud Ct).

Justice Knowlton noted at 266:

> *If the claimant's behavior was such as to indicate consent on her part, [the surgeon] was justified in his act, whatever her unexpressed feelings may have been. In determining whether she consented, he could be guided only be her overt acts and the manifestations of her feelings.*

Justice Knowlton emphasized that consent should be implied from the circumstances and the conduct of the patient.

'For the purposes of surgery, it is usual to obtain written consent from the patient except in an emergency.'[211] It is a good practice to also obtain consent for procedures of a minor nature.

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[209] Above n 188, 148.
[210] Above n 188, 148.
[211] Above n 138.

In New Zealand, Right 7 (6) of the *Code of Health and Disability Services Commissioners Rights 1996* states that:

> *Where informed consent to a health care procedure is required, it must be in writing if –*
>
> *a) The consumer is to participate in any research; or*
> *b) The procedure is experimental; or*
> *c) The consumer will be under general anesthetic; or*
> *d) There is a significant risk of adverse effects on the consumer.*

The Ontario province in the Canadian jurisdiction has statutory provisions in the *Health Care Consent Act 1996* (Ontario) to deal with issues concerning types of consent.

Section 11 (4) of the said Act stipulates that:

> *Consent to treatment may be express or implied.*

Unlike the Canadian jurisdiction, there are no statutory provisions for the various types of consent in the United Kingdom, Australia, New Zealand and Fiji jurisdictions.

3.10 When the Patient's Consent is not required?

The circumstances in which consent to medical treatment is not needed may differ based upon the following exceptions. However, in the absence of any such exception, any medical treatment carried out on the patient without his/her consent may amount to an action in *trespass*.

(i) Application of the doctrine of necessity

'The basis of the doctrine of necessity is that acting unlawfully is justified if the resulting good effect materially outweighs the consequences of adhering strictly to the law, therefore, the doctor is justified and should not have criminal or civil liability imposed upon him if the value, which he seeks to protect, is of greater weight than the wrongful act he performs by treating without consent.'[212]

This doctrine was recognized in the English case of *F v West Berkshire Health Authority and another (Mental Health Commission intervening)* [1989] 2 All ER 545.

The facts of the case are as follows:[213]

> The plaintiff was an adult woman with mental disability. She had formed a sexual relationship with a male patient and there was medical evidence that from a psychiatric point of view, it would be disastrous for her to become pregnant. The plaintiff was not in a position to give consent therefore a declaration was sought from the court to carry out sterilization procedure on her.

Lord Brandon in a majority judgment noted at 551:

> *In my opinion, the solution to the problem which the common law provides is that a doctor can lawfully operate on, or give other treatment to, adult patients who are incapable, for one reason or another, of consenting to his doing so, provided that the operation or other treatment concerned is in the best interests of such patients. The operation or other treatment will be in their best interests of such patients. The operation or other treatment will be in their best interests if, but only if, it is carried out in order either to save*

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[212] S.S. Sagar Priyatham & K. Prathima, 'Consent and Informed Consent' (2002) http://www.mondaq.com/article.asp?articleid=17910 (16 April 2008)

[213] *F v West Berkshire Health Authority and another* (Mental Health Commission intervening) [1989] 2 All ER 545.

> *their lives or to ensure improvement or prevent deterioration in their physical or mental health.*
>
> *In many cases, however, it will not only be lawful for doctors, on the ground of necessity, to operate on or give other medical treatment to adult patients disabled from giving their consent: it will also be their common law duty to do so.*

Lord Brandon indicated that where a patient is unable to give consent, the doctor can lawfully treat the patient in his or her best interest under the common law doctrine of necessity. Lord Jauncey in agreement noted at 571 that 'in the case of a long-term incompetent, convenience to those charged with his care should never be a justification for the decision to treat'.

This doctrine was applied later in the case of *R v Bournewood Community and Mental NHS Trust, ex parte L (Secretary of State for Health and others intervening)* [1998] 3 All ER 289.

Lord Steyn in a majority judgment noted at 307:

> *The starting point of the common law is that when a person lacks capacity, for whatever reason, to take decisions about medical treatment, it is necessary for other persons, with appropriate qualifications, to take such decision for him: F v West Berkshire Health Authority (Mental Health Act Commission intervening) [1989] 2 All ER 545 at 551, [1990] 2 AC 1 at 55 per Lord Brandon of Oakbrook. The principle of necessity may apply. For the purposes of the present case it has been assumed by all counsel that the requirements of the principle are simply that (1) there must be 'a necessity to act when it is not practicable to communicate with the assisted person' and (2) 'that the action taken must be such as a reasonable person would in all circumstances take, acting in the best interests of the assisted person'(see F's*

> *case [1989] 2 All ER 545 at 565-566, [1990] 2 AC 1 at 75 per Lord Goff of Chieveley).*

Further application of this doctrine was in *Re A* (medical treatment: male sterilization) [2001] 1 FLR 549.

The facts of the case are as follows:[214]

> A, an adult male of 28 years old was suffering from Down's syndrome with severe impairment of intelligence. He was under the care and supervision of his 63 year old mother. However, the mother's health was not good and she was concerned that when A moved into local authority care, he might have a sexual relationship resulting in the birth of a child. A is not capable to understand the consequences or bear the responsibility of bringing up a child. Declaration was sought from the High Court by the mother in relation to a vasectomy operation.

President Butler-Sloss in a majority judgment noted at 9:

> *An application on behalf of a man for sterilisation is not the equivalent of an application in respect of a woman. It is not a matter of equality of the sexes but a balancing exercise on a case by case basis. There are obvious biological differences and sexual intercourse for a woman carries the risk of pregnancy which patently it does not for a man. Indeed there is no direct consequence for a man of sexual intercourse other than the possibility of sexually transmitted diseases. There may be psychological consequences for him in pregnancy or in the birth of his child. He may be required to take responsibility for the child after birth and may, in certain circumstances attract disapproval and criticism. In the case of a man who is mentally*

[214] *Re A* (medical treatment: male sterilization) [2001] 1 FLR 549 http://www.cirp.org/library/legal/Re_A2000\ (Assessed 2 may 2009).

incapacitated, neither the fact of the birth of a child nor disapproval of his conduct is likely to impinge on him to a significant degree other than in exceptional circumstances. His freedom of movement might in certain be restricted and consequently his quality of life might be diminished. It is possible that there may be other disadvantages to the person concerned which might lead a court to decide to approve the operation. It may be necessary to evaluate the nature and degree of risk attached to approval of or refusal to approve the operation to sterilise. But the task in each case is to balance all the relevant factors and to decide what are the best interests of the person unable to make his own decision.

In the present appeal it is necessary to focus upon the best interests of A himself. It is clear from the evidence of his mother that, as long as she cares for him, he will continue to be subjected to the present regime of close supervision. The refusal to approve the operation will inevitably upset A's mother but her care of him will not be diminished nor will he be aware that she is upset. If sterilisation did take place, it would not save A from the possibility of exploitation nor help him cope with the emotional implications of any closer relationship that he might form.

When in due course he goes into local authority care, the degree of freedom might be affected by the fear that he might form a sexual relationship with another resident. It would however, in my view, be likely that the woman concerned would be the object of protection rather than A. If his quality of life were, however, to be diminished, that would be a reason to seek at this time a hearing before a High Court judge to grant a declaration that sterilisation would then be in A's best interests.

President Butler-Sloss applied the “best interest” principle under the doctrine of necessity. In doing so, he emphasized upon his earlier decision in *Re MB* (an adult: medical treatment) [1997] 2 FCR 541 where he noted at 555 ‘best interests are not

limited to best medical interests'[215]. President Butler-Sloss stated that the 'best interests encompasses medical, emotional and all other welfare issues'[216]. Furthermore, President Butler-Sloss held that 'in the case of an application for approval of a sterilization operation, it is the judge, not the doctor, who makes the decision that it is in the best interests of the patient that the operation be performed'[217].

President Butler-Sloss in applying the "best interest" principle noted the case of women with intellectual disabilities where the sterilization procedure has been authorized (*Re M (A Minor) (Wardship: Sterilisation)* [1988] 2 FLR 597; *Re B (A Minor: Wardship: Sterilisation):* [1988] AC 189; *Re W (Mental Patient: Sterilisation)* [1993] 1 FLR 381; *Re X (Adult Sterilisation)* [1998] 2 FLR 1124) and in cases where the procedure has not been authorized (*Re D (A Minor) (Wardship: Sterilisation)* [1976] Fam 185; *Re LC (Medical Treatment: Sterilisation)* [1997] 2 FLR 258).[218] In any event, the principle of "best interest" under the doctrine of necessity was applied in each of the cases. President Butler-Sloss noted the anatomical distinction between male and female and held that 'if sterilisation did take place, it would not save A from the possibility of exploitation nor help him cope with the emotional implications of any closer relationship that he might form'[219].

Furthermore, President Butler-Sloss emphasized upon the timing of this application and held that if A forms a sexual relationship with another resident and his quality of life were, however, to be diminished, then that would be a reason to seek at that time a hearing before a High Court judge to grant a declaration that sterilisation would then be in A's best interests.[220]

[215] Above n 214, 7.
[216] Above n 214, 8.
[217] Above n 214, 1.
[218] Above n 214.
[219] Above n 214, 2.
[220] Above n 214.

In the Australian jurisdiction, this doctrine of necessity was applied in *Re Katie* (1996) FLC 92-659.

The facts of the case are as follows:[221]

> The patient is a severely retarded post pubertal girl of 16 years. She resides with her family and will continue to do so as long as her parents were physically capable of providing the care. Her parents were responsible to take care of her personal hygiene. She suffers mood changes and severe pain before menstruation and it worsens during actual menstruation. Her parents applied to the Court for authorization to consent to the carrying out of a sterilization procedure on Katie.

Justice Warnick in a single judgment noted at 82,817:

> *To assess the significance of Katie, one must look at her total circumstances. She has been raised as part of the family. The intention is that she continues to be so. I infer that Katie's emotional welfare is best served by her continuing to reside in the family and by the demands of her presence being lessened as much as possible, to maximize the ability of the family, in particular the mother, to cope with Katie's needs. Thus the interests of Katie are inextricably linked with the ability of her parents to cope with the burdens of Katie's care.*

Justice Warnick indicated that in situations such as this, the best interest of the patient must be given paramount consideration and in doing so, the benefits of the parents and their connection to the welfare of the child must be taken into consideration.[222]

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[221] *Re Katie* (1996) FLC 92-659.
[222] Above n 221, 82,817.

In New South Wales**,** section 37 (1) of the *Guardianship Act 1987* (NSW) stipulates that:

> *Medical or dental treatment may be carried out on a patient to whom this Part applies without consent given in accordance with this Part if the medical practitioner or dentist carrying out or supervising the treatment considers the treatment is necessary, as a matter of urgency:*
>
> *(a) to save the patient's life, or*
>
> *(b) to prevent serious damage to the patient's health, or*
>
> *(c) except in the case of special treatment-to prevent the patient from suffering or continuing to suffer significant pain or distress.*

In the Canadian jurisdiction, 'this [doctrine of necessity] is laid down in two well-known Canadian cases where the courts explored the distinction between procedures justified by necessity and those, which are merely convenient'[223]. This principle of necessity was applied in the case of *Marshall v Curry* [1933] 3 DLR 260.

The facts of the case are as follows:[224]

> The patient visited the surgeon for hernia operation. During the operation the surgeon removed a diseased testicle. The surgeon was of the opinion that had he not removed the diseased testis, the health and life of the patient would have been periled. The patient claimed that he had not consented for the removal of the testicle.

'Taking the view that the doctor had acted for the protection of the plaintiff's health and possibly his life, the court held that the removal of the testicle was necessary and that it would have been unreasonable to put the procedure off until a later date.'[225]

[223] Above n 212.
[224] Above n 212.
[225] Above n 212.

The principle of necessity should not be applied in situations where it is merely convenient to do so. This view was taken into consideration in *Murray v McMurchy* [1949] 2 DLR 442.

The facts of the case are as follows:[226]

> The doctor during Caesarean section discovered that the condition of plaintiff's uterus was such that it would have made it hazardous for her to go through pregnancy. The doctor went ahead and tied the fallopian tubes without any pressing need to do so. The patient claimed that she had not consented to the treatment.

'The court held that it would not have been unreasonable in the circumstances to postpone the sterilization until after consent had been taken.'[227]

From the analysis of the above cases, it is evident that the principle of "best interest" under the doctrine of necessity is applicable in the English, Australian and Canadian jurisdictions. Furthermore, it is noted that the doctrine applies in situations where it is necessary to do so and not in situations of mere convenience. The "best interest" of the patient is given paramount consideration to in the above jurisdictions.

However, in the Australian jurisdiction it was noted that the "best interest" of the patient must be determined by taking the full circumstances of the patient into consideration. In doing so, the benefits of the parents and their connection to the welfare of the patient must be taken into account. This doctrine has been codified in New South Wales.

(ii) Emergency

[226] Above n 212.
[227] Above n 212.

In an emergency situation, consent to medical treatment is implied in the circumstances whereby an 'immediate medical or surgical intervention is necessary to prevent death or serious harm to the patient'[228]. 'In these instances, the consent standards are not followed because immediate treatment may be required even before an opportunity to obtain consent is available.'[229] The assumption is that a reasonable competent person in a life-threatening situation would agree to undergo the treatment, if able to consent.[230]

This emergency exception in relation to consent to medical treatment was taken into consideration in the English case of *Wilson v Pringle* [1987] 3 WLR 1.

Lord Justice Croom-Johnson in a majority judgment noted at 10:

> *This rationalism by Robert Goff L.J draws the so-called "defences" to an action for trespass to the person (of which consent, self-defence, ejecting a trespasser, exercising parental authority, and statutory authority are some examples) under one umbrella of 'a general exception embracing all physical contact which is generally acceptable in the ordinary conduct of daily life."*
>
> *It provides a solution to the old problem of what legal rule allows a casualty surgeon to perform an urgent operation on an unconscious patient who is brought into hospital. The patient cannot consent, and there may be no next-of-kin available to do it for him. Hitherto it has been customary to say in such cases that consent is to be implied for what would otherwise be a battery on the unconscious body. It is better simply to say that the surgeon's action is acceptable in the ordinary conduct of everyday life, and not a battery. It will doubtless be convenient to continue to tie the labels of the*

[228] 'Health Care Risk Control', (2008) https://www.ecri.org/Documents/Sample_HRC_Informed_Consent_Report.pdf (Assessed 6 May 2009).
[229] 'Consent', http://www.ourmugshots.com/MD%20Database/Consent.doc (Assessed 6 May 2008)
[230] Above n 229.

"defences" to the facts of any case where they are appropriate. But the rationalization explains and utilizes the expressions of judicial opinion which appear in the authorities. It also prevents the approach to the facts, which, with respect to the judge in the present case, causes his judgment to read like a ruling on a demurer in the days of special pleading.

Lord Justice Croom-Johnson indicated that the application of the emergency exception will act as a defence in an action for *trespass* cases. The surgeon's action will be acceptable if the treatment is carried out without the patient's consent in an emergency situation, where the immediate intervention was necessary to save the life of the person.

'Where treatment is necessary but the patient is temporarily incapacitated, it has been held that a medical practitioner has been justified 'in taking such steps as good medical practice demands.'[231] This principle was discussed within the context of the emergency exception in the case of *T v T* (1988) 2 WLR 189.

The facts of the case are as follows:[232]

> The first defendant, a 19 year old female with severe mental handicap was found to be 11 weeks advance in pregnancy. The doctors recommended termination of pregnancy and sterilisation. Declaration was sought from the court to carry out the said procedures.

Justice Wood in a single judgment noted at 199:

> *I prefer to approach the problem in this way. This defendant is never going to be able to consent- we are not dealing with a temporary inability such as a person under an anesthetic, I compare the Canadian cases Marshall v Curry*

[231] Above n 169.
[232] *T v T* (1988) 2 WLR 189.

(1933) 3 DLR 260 and Murray v McMurchy (1949) 2 DLR 442, and there is no one in a position to consent. A medical adviser must therefore consider what decisions should be reached in the best interests of his patient's health. What does medical practice demand?

I use the word "demand" because I envisage a situation where based upon good medical practice there are really no two views of what course is for best. Upon the facts of this case I accept the medical evidence that not only would it be contrary to the defendant's best interests to postpone these procedures, but it positively in her best interests to proceed with due dispatch.

It might be argued that sterilisation could reasonably be postponed for further consideration, and indeed, that was my own first reaction, but after hearing argument I am quite satisfied that the risks to the defendant of a second operation, coupled with the doubts whether it could in fact be achieved in the light of her strength and inability to understand, are such as to be unacceptable, and I have no doubt that her best interests demand that all appropriate procedures to this end are carried out at the same time as the termination.

The third basis upon which these declarations could be made is that the operations would not in fact be tortuous acts. This submission was perfectly straightforward and relied upon the authority of Wilson v Pringle [1987] QB 237.

Justice Wood indicated that in an emergency situation, the best interest of the patient must be taken into account with emphasis upon good medical practice. Furthermore, Justice Wood referred to *Wilson v Pringle* and held that 'in order to constitute

trespass to the person the act itself must be intentional and hostile and that no act of a doctor treating his patient could be said to be hostile'[233].

This emergency exception as it applies to the practice of general medicine has not been codified under the English law. However, it has been codified in South Australia.

In South Australia, section 13 (1) of the *Consent to Medical and Palliative Care Act 1995* (SA)[234] stipulates that:

> *Subject to subsection (3), a medical practitioner may lawfully administer medical treatment to a person (the "patient") if—*
>
> *(a) the patient is incapable of consenting; and*
> *(b) the medical practitioner who administers the treatment is of the opinion that the treatment is necessary to meet an imminent risk to life or health and that opinion is supported by the written opinion of another medical practitioner who has personally examined the patient; and*
> *(c) the patient (if of or over 16 years of age) has not, to the best of the medical practitioner's knowledge, refused to consent to the treatment.*

This section takes into account the principles of emergency exception as outlined in *T v T*.

From the analysis of the above cases, it is evident that the emergency exception has been applied in the English jurisdiction in the circumstances where an immediate medical or surgical intervention is necessary to save the life of the patient. The emergency exception takes into account the best interests of the patient within the

[233] Above n 232.
[234] This Act has been amended by the *Consent to Medical and Treatment and Palliative Care* (Prescribed Forms) *Amendment Act 2004*. However, the above provision remains the same.

context of good medical practice. This exception allows the surgeon to treat the patient without his or her consent in an emergency situation and amounts to a defence in *trespass* cases. This principle has been codified in South Australia.

It is submitted that the patient's medical record must be noted accordingly, including details of the emergency circumstances under which the patient presented, the need for an immediate medical or surgical intervention and the treatment that was provided without consent. These details will be very useful in defending the doctor or the healthcare provider against any actions that might arise in *trespass*. It is important to note that the emergency exception cannot be used to override a competent adult patient's earlier specific refusal to treatment.

(iii) Waiver by patient

In certain situations 'the patient may expressly waive the right to be informed of the risks and alternatives to treatment'[235]. The practical thing to do in these situations is to have the patient sign the waiver form and the medical record of the patient noted accordingly. It is also reasonable that the doctor informs the patient about the risks of refusing the treatment and giving the patient some time to think about the said decision.

(iv) Therapeutic Privilege

In certain situations, 'therapeutic privilege has been used to justify the deliberate withholding of information from a patient where the patient's doctor considers that disclosure of particular information could pose a threat of actual or psychological harm to the patient'[236].

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[235] 'Informed Consent', (2005) http://www.pinsco.com/downloads/reducing_risk/NJ.Informed.Consent.June05.pdf (Assessed 6 May 2005)

[236] Carolyn Johnston, 'The status of Therapeutic Privilege – legal and ethical consideration' http://www.liv.ac.uk/law/slsa/streams/health.htm#9 (Assessed 7 May 2009).

'It has been considered that therapeutic privilege is limited to situations where the doctor holds the opinion that the patient would not be able to deal with particular facts relevant to the treatment.'[237]

This principle of therapeutic privilege was taken into consideration in the South Australian case of *Battersby v Tottman and State of South Australia* [1984] 35 SASR 577.

The facts of the case are as follows:[238]

> The patient is 53 year old married woman suffering from severe mental illness. She was treated at Hillcrest Hospital and for some time was under the care of Dr. Tottman. Her treatment included the administration of large doses of a drug called melleril. The plaintiff whilst under treatment at Hillcrest Hospital developed an eye condition known as pigmentary retinopathy which is a clumping or rarefaction of pigment on the retina of the eye. This condition led to serious and permanent damage to her eyesight. The retinopathy was caused by the melleril treatment. The patient claimed that the Dr. Tottman failed to warn her of the risks and side effects of the melleril treatment.

Justice Cox in a single judgment noted at 584 - 585:

> *Next, the plaintiff submits that Dr. Tottman was negligent in failing to warn her of the possible consequences of the melleril treatment. It is obvious that, in the case of a normal patient, a doctor who prescribed a drug in doses far exceeding the recommended maximum, where there was a known possible side effect of severe eye damage, would be failing badly in his professional responsibility if he omitted to warn the patient of the risk he was taking. The*

[237] Above n 236.
[238] *Battersby v Tottman and State of South Australia* [1984] 35 SASR 577.

purpose of such warning would be two-fold to let the patient decide for himself whether he would accept the treatment in those circumstances and, if he did so decide, to put him on the alert for the earliest signs of skin pigmentation or visual loss.

The plaintiff, however, was not a normal patient. She was very severely mentally disturbed. She was acutely depressed and suicidal. Those personality and behavioural features continued, in varying degrees of intensity, throughout the relevant period. She told Dr. Tottman that she had always had a dreadful fear of something going wrong with her eyes. This accords with the plaintiff's own evidence at the trial. Dr. Tottman feared that, if he did tell the plaintiff about the risk to her eyesight from taking melleril, one of two things would happen – she would have an hysterical reaction and get the symptoms of an actual eye defect (and therefore have to be taken off the melleril) or she would, openly or surreptitiously, stop taking the melleril of her own accord. She was, as I have said, a high suicide risk. If she stopped taking the melleril she would probably kill herself. While the consequences of melleril retinopathy are obviously not to be undated, it is important to remember that Dr. Tottman believed that the condition was arrestable, if not reversible, when discovered and that pigment changes in the skin might give a warning sign before actual eye damage occurred. His beliefs in this respect were not unreasonable in the light of what was known about the drug in this State between 1970 and 1974.

In my opinion, Dr. Tottman was not negligent in deciding not to warn the plaintiff of the risk involved in the melleril treatment.

Justice Cox indicated that the doctor can in certain situations apply the principles of therapeutic privilege in withholding certain information from a patient if the doctor is of the opinion that the information if disclosed will cause harm to the patient.

This principle of therapeutic privilege was referred to in the case of *Rogers v Whitaker*.

Justice Gaudron in a majority judgment noted at 493-494:

> *Whether the position is considered from the perspective of the individual patient or from that of the hypothetical prudent patient and unless there is some medical emergency or something special about the circumstances of the patient, there is simply no occasion to consider the practice or practices of medical practitioners in determining what information should be supplied. However, there is some scope for a consideration of those practices where the question is whether, by reason of emergency or the special circumstances of the patient, there is no immediate duty or its content is different from that which would ordinarily be the case.*
>
> *And as at present advised, I see no basis for any exception or "therapeutic privilege" which is not based in medical emergency or in considerations of the patients ability to receive, understand or properly evaluate the significance of the information that would ordinarily be required with respect to his or her condition or the treatment proposed.*

Justice Gaudron indicated that certain information can be withheld from the patient if the circumstances of that patient are special. The reason being that disclosure of this information to a patient who does not have the ability to receive, understand and properly evaluate the significance of that information, can pose threat or harm to that patient.

From the analysis of the above cases, it is evident in the Australian jurisdiction that doctors can withhold certain information from the patient if they are of the opinion that the information if disclosed will harm the patient.

It is submitted that the justification for invoking this privilege must be documented in the patient's medical records. The justification should include the information that was withheld, the basis for non-disclosure, the special circumstances of the patient and the information that was disclosed. These details will be very useful in defending the doctor or the healthcare provider against any actions that might arise in *negligence*.

(v) Waiver by Statute

In certain situations, the legislation has specific statutory provisions that waive the rights of individuals to certain medical procedures.

In New South Wales, section 22 (1) of the *Public Health Act 1991* (NSW) stipulates that:

> *The Director-General may, by written notice, require a named person to undergo a medical examination that:*
>
> *(a) is carried out by a medical practitioner chosen by the person, and*
> *(b) is of a kind described in the notice,*
>
> *if the Director-General believes on reasonable grounds that the person is suffering from a Category 4 or Category 5 medical condition.*[239]

In the Australian Capital Territory, section 16 (2) of the *Road Transport* (Alcohol and Drugs) *Act 1977* (ACT)[240] stipulates that:

> *If a police officer has reasonable cause to suspect—*

[239] For the purpose of this Act Category 4 diseases include Avian influenza in humans, Severe Acute Respiratory Syndrome, Tuberculosis, Typhoid and Category 5 diseases include Acquired Immune Deficiency Syndrome & Human Immunodeficiency Virus infection.
[240] This Act has been amended by the *Road Transport* (Alcohol and Drugs) *Amendment Act* 2006 (ACT). However, the above provision remains the same. Section 16 (4) of the said Act provides provision that the medical examination shall be carried out within 2 hours of the person's arrival at hospital.

(a) that a person to whom this section applies has in his or her body a drug other than alcohol; or

(b) that the behaviour of the person does not arise, or does not wholly arise, from the presence of alcohol in his or her body;

the police officer may require that person to submit to a medical examination and to give, or permit the taking of, body samples in accordance with this section for the purpose of ascertaining whether the condition of the person is caused, or contributed to, by the presence in his or her body of a drug other than alcohol.

In Fiji, section 85 (1) of the *Public Health Act* [Cap 111] stipulates that:

A medical officer of health in any case where in the interests of public health he thinks expedient so to do, may, by order in writing-

(a) direct any person suffering or suspected to be suffering from any venereal disease to attend a hospital or registered medical practitioner for examination and treatment if necessary, and may specify the hospital or medical practitioner to be attended by such person;

(b) direct that any such person who is found to be suffering from venereal disease be detained and remain in hospital until discharged there from buy a medical officer of health;

(c) direct any sanitary inspector or any officer of the Board to remove to hospital any person failing to comply with an order made under the provisions of paragraphs (a) or (b).

From the analysis of the above statutes, it is evident that in certain situations, the patient's right to make his/her own decision about the choice of medical treatment is overridden by statutory provisions. These provisions in relation to compulsory medical examination are embodied into the legislation to safeguard the interests of

the general public. Furthermore, it is noted that this provision applies in very special circumstances such as during an outbreak of infectious disease. In Australian Capital Territory, the Police Officers rely upon this exception to carry out alcohol blood analysis in the blood of motor vehicle drivers.

3.11 Vitiating Consent

Consent to medical treatment is vitiated if the consent is provided under fraudulent misrepresentation, undue pressure or sedation.

In the English jurisdiction, this view was taken into consideration in *Re T* (adult: refusal of medical treatment) [1992] 4 All ER 649.

The facts of the case are as follows:[241]

> The patient was injured in a car accident. She was 34 weeks pregnant when admitted to the hospital. There was a possibility of blood transfusion. The patient was brought up by her mother, who was a Jehovah's Witness, but she herself was not a member of that religious sect. After conversing with her mother privately, the patient informed the staff nurse that she did not want a blood transfusion. After undergoing an emergency Caesarean operation her condition deteriorated and she was transferred to an intensive care unit where the consultant anesthetist would have administered a blood transfusion but inhibited to do so in the light of the patient's wishes. Her father and her boyfriend applied to the Court for authorization of a blood transfusion.

Lord Donaldson MR in a majority judgment noted at 664:

> *In some cases doctors will not only have to consider the capacity of the patient to refuse treatment, but also whether the refusal has been vitiated*

[241] *Re T* (adult: refusal of medical treatment) [1992] 4 All ER 649.

because it resulted not from the patient's will, but from the will of others. It matters not that those others sought, however strongly, to persuade the patient to refuse, so long as in the end the refusal represented the patient's independent decision. If, however, his will was overborne, the refusal will not have represented a true decision. In this context the relationship of the persuader to the patient, for example, spouse, parents, or religious adviser, will be important, because some relationships more readily lend themselves to overbearing the patient's independent will than do others.

Lord Donaldson emphasized that the patient's consent to medical treatment will be vitiated if his/her decision is not independent. The undue pressure placed by the family members is just one contributing factor. However this does not amount to vitiating consent if the decision was made independently by the patient without any reliance on the views of others.

In the Canadian jurisdiction, the factors contributing to vitiating a patient's consent to medical treatment was discussed in *Beausoleil v Sisters of Charity* (1964) 53 DLR 2d 65.

The facts of the case are as follows:[242]

> The patient was unmarried female of 29 years old. She visited Hospital du Sacre Coeur complaining of backaches. The orthopaedic surgeon recommended a disc operation. The patient consented to a general anaesthetic. The patient was given sedation and taken to the operating room where she told the staff anaesthetist that she did not want a spinal. Dr Forest, Chief anaesthetist intervened and talked the patient into submitting to the spinal which was administered. As a result the patient was permanently paralysed from the waist down. The patient claimed she consented to general anaesthetic and not a spinal.

[242] Peter MacFarlane, *Health Law in Australia & New Zealand: Commentary and Materials* (3rd ed) at 61.

Justice Casey in a majority judgment noted:[243]

> *But when in cases in which there is no urgency the doctor for one reason or another is unwilling to render the services agreed upon by the patient the only course of action open to him is to withdraw. He must not overrule his patient and submit him to risks that he is unwilling and in fact has refused to accept.*

Justice Casey indicated that the patient's consent to medical treatment is vitiated if that consent is provided under undue pressure of the doctor. Justice Casey held that 'the vital question is whether or not the appellant gave a full and free consent to the change from general anaesthetic to a spinal one. In this instant the consent was not voluntarily provided.

Consent to medical treatment can be vitiated if that consent is provided by the patient under sedation. This was discussed in the Canadian case of *Ciarlariello v Schacter* (1993) 100 DLR (4th) 609.

Justice Cory in single judgment noted at 619-620:

> *The issue as to whether or not consent has been withdrawn during the course of a procedure may require the trial judge to make difficult findings of fact. If sedatives or other medication were administered to the patient, then it must be determined if the patient was so sedated or so affected by the medication that consent to the procedure could not effectively have been withdrawn. The question whether a patient is capable of withdrawing consent will depend on the circumstances of each case. Expert medical evidence will undoubtedly be relevant, but will not necessarily be determinative of the issue.*

[243] Above n 242, 62.

Justice Cory's view was that the patient must be conscious to give consent to medical treatment. If the patient is under sedation or other medication his capability to make rational decision about the choice of medical treatment would be flawed and thus any consent provided will be vitiated.

From the analysis of the above cases, consent to medical treatment is vitiated if that consent is provided under undue pressure by family members or the healthcare personnel's. Furthermore consent is also vitiated if that consent is provided when the patient is under sedation.

3.12 Assessing the Patient's Capacity to Consent to Medical Treatment[244]

It is a complex task to ascertain the fact whether consent to medical treatment was actually given. 'Consent may be implied within the usual subtleties of human communication, rather than explicitly negotiated verbally or in writing.'[245] The central issue is whether the patient has the capacity to give consent to the proposed medical treatment.

3.121 Assessment of Capacity to give Consent

The patient is capable of giving consent to a proposed medical treatment if he/she has the ability to understand the information disclosed in the decision-making process and has the ability to make his/her own decision on the choice of treatment based on that information. The assessment of capacity to give consent to medical treatment is based on the question of facts and may differ on case-to-case basis.

(i) Incompetent Persons

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[244] Elements of valid consent are discussed in 3.8. This section only focuses on the assessment of capacity to give consent to medical treatment.
[245] Above n 143.

An incompetent person is a person under mental disability. 'In most instances, the issue will be whether the patient's mental disability or disorder is such that he[/she] has lost the capacity to consent or refuse treatment or has never acquired it.'[246]

In the English jurisdiction, a three-stage test to assess an incompetent persons capacity to give consent to medical treatment was formulated in the case of *Re C* (adult: refusal to treatment) [1994] 1 All ER 819.

The facts of the case are as follows:[247]

> The patient is 68 years old suffering from paranoid schizophrenia. The patient developed gangrene in a foot whilst serving seven-year term of imprisonment. The consultant surgeon's prognosis was that the patient would die imminently if the leg was not amputated below the knee. The patient refused to consider amputation and an injunction was sought on his behalf from the court restraining the hospital from carrying out an amputation without his express written consent.

Justice Thorpe in a single judgment noted at 824:

> *I consider helpful Dr Eastman's analysis on the decision-making process into three stages: first, comprehending and retaining treatment information, second, believing it and, third, weighing it in the balance to arrive at choice.*

Justice Thorpe held that 'in determining whether that person had sufficient capacity to refuse treatment, the question to be decided was whether it had been established that his capacity had been so reduced by his chronic mental illness

[246] Above n 188, 160.
[247] *Re C* (Adult: refusal to treatment) [1994] 1 All ER 819.

that he did not sufficiently understand the nature, purpose and effects of the proffered medical treatment'[248]. Furthermore, Justice Thorpe applied the three-stage test and held that this 'in turn depended on whether he had, [i] comprehended and retained information as to the proposed treatment, [ii] had believed it and [iii] had weighed it in the balance when making a choice. In this particular instant, the court applied this test and held that the incompetent person had the capacity to make his/her own decision about the choice of medical treatment.

'This test has been applied not only in adult cases, but also in child cases where the issue of the child's capacity is not a developmental one of maturity but is raised by the child's mental disability.'[249] This three-stage test was applied in *Re MB* (an adult: medical treatment).

Lord Justice Butler-Sloss in a majority judgment noted:[250]

> *A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent to or refuse treatment; That inability to make a decision will occur when*
>
> *(a) the patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question.*
> *(b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision. If ... a compulsive disorder or phobia from which the patient suffers stifles belief in the information presented to her, then the decision may not be a true one.*

[248] Above n 247.
[249] Above n 188, 163.
[250] Above n 188, 163.

Lord Justice Butler-Sloss in applying the three-stage test further held that 'the external factors such as confusion, shock, fatigue, pain or medication may temporarily affect the patient's ability to understand'[251].

In the Australian Capital Territory (ACT), *Calvary Health Care Consent Policy 2004*[252] outlines a series of questions which will enable the clinician to assess competency in accordance with accepted best practice:[253]

Comprehension (understanding)

- *Ask the patient to recall and paraphrase information related to proposed treatment, including risks and benefits of treatment, alternative treatment and consequences of no treatment at all.*
- *Retest later to check for continued understanding.*

Belief (appreciation)

- *Tell me what you really believe is wrong with your health now?*
- *Do you believe that you need some kind of treatment?*
- *What is the treatment likely to do for you?*
- *Why do you think it will have that effect?*
- *What do you believe will happen if you're not treated?*
- *Why do you think the doctor has recommended this treatment for you?*

Weighing (reasoning)

- *Tell me how you reached the decision to accept (reject) treatment.*
- *What things were important to you in reaching the decision?*
- *How do you balance those things?*

Choice

- *Have you decided whether to go along with your doctor's suggestion for treatment?*

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[251] Above n 188, 163.
[252] Above n 169.
[253] Above n 169.

- *Can you tell me what your treatment decision is?*

This policy is based on the three-stage test formulated in *Re C.*

It is of essence that the assessment is carried out in a non-technical language and the questions, answers and conclusions pertaining to competency be documented to ensure evidence trail exists.[254]

(ii) <u>Minors</u>

There are statutory provisions available under the domestic law of English, Australian, New Zealand and Canadian jurisdictions whereby the actual age at which a person can consent to medical treatment is stipulated to be 16 years or above. However, the position of a child under the age of 16 years pertaining to his/her capacity to consent to his/ her choice of medical treatment is clarified at common law.

The law governing consent to medical treatment of minors under the age of 16 years is stipulated by case laws whereby judges have set certain standards of competency that minors have to meet in order to provide consent to their own treatment.

In the English jurisdiction, the common law has set the *Gillick* competency standard based upon the decision of the House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402.

The facts of the case are as follows:[255]

> The Department of Health and Social Security ("DHSS") issued guidance in 1980 on family planning services for young people, which stated or

[254] Above n 169.
[255] *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402.

implied that at least in certain cases which were described as 'exceptional', a doctor could lawfully prescribe contraception for a girl under 16 without her parent's consent. Mrs Gillick, a mother of five daughters all under the age of 16 objected to the guidance and sought declaration from the court against the appellants that the advice given in the guidance was unlawful.

Lord Scarman in a majority judgment noted at 423-424:

In the light of the forgoing I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give consent valid in law. Until the child achieves the capacity to consent, the parental right to make the decision continues save only in exceptional circumstances. Emergency, parental neglect, abandonment of the child or inability to find the parent are examples of exceptional situations justifying the doctor proceeding to treat the child without parental knowledge and consent; but there will arise, no doubt, other exceptional situations in which it will be reasonable for the doctor to proceed without the parent's consent.

When applying theses conclusions to contraceptive advice and treatment it has to be borne in mind that there is much that has to be understood by a girl under the age of 16 if she is to have legal capacity to consent to such treatment. It is not enough that she should understand the nature of the advice which is being given; she must also have a sufficient maturity to understand what is involved.

Justice Scarman indicated that a minor under the age of 16 years has the capacity to give consent to medical treatment provided that he/she has sufficient maturity to understand the nature, purpose and effect of the proposed treatment or advice. Furthermore, Lord Scarman held that 'the proper course for the doctor will be to persuade the girl to bring her parents into consultation and, if she refuses, not to prescribe contraceptive treatment unless he is satisfied that her circumstances are such that he ought to proceed without parental knowledge and consent'[256]. However, it is important to note that the *Gillick* competency standard is limited in its application and does not extend to an incompetent minor. An incompetent minor is a minor under the age of 16 years with mental disability.

The position in relation to a minor with mental disability was discussed in the case of *Re R* (A Minor) (Wardship: Consent Treatment) [1991] 3 WLR 592 (CA).

The facts of the case are as follows:[257]

> The patient, a minor, 15 year-old-female was suffering from severe mental disability with violent and suicidal behaviour. She was under the care of the local authority. Following such an episode, she was detained in the hospital and admitted to an adolescent psychiatric unit where the proposed treatment included the compulsory administration of certain anti-psychotic drugs. The local authority consented to the proposal. However, the patient indicated that she would refuse any such treatment. The local authority initiated wardship proceedings, applying for leave to permit the unit to administer the proposed medication without the patient's consent.

Lord Donaldson MR in a majority judgment noted at 601:

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[256] Above n 255, 424.

[257] *Re R* (A Minor) (Wardship: Consent Treatment) [1991] 3 WLR 592 (CA).

Such a [Gillick competent] child can consent, but if he or she declines to do so or refuses, consent can be given by someone else who else has parental rights or responsibilities. The failure or refusal of the "Gillick competent" child is a very important factor in the doctor's decision whether or not to treat, but does not prevent the necessary consent being obtained from another competent source.

And at 602-603:

The House of Lords in [Gillick's] case was quite clearly considering the staged development of a normal child… But there is no suggestion that the extent of this competence can fluctuate upon a day to day or week to week basis. What is really being looked at is an assessment of mental and emotional age, as contrasted with chronological age, but even this test needs to be modified in the case of fluctuating mental disability to take account of that misfortune…But, even if she was capable on a good day of a sufficient degree of understanding to meet the Gillick criteria, her mental disability, to the cure or amelioration of which the proposed treatment was directed, was such that on other days she was not only "Gillick incompetent" but actually sectionable. No child in that situation can be regarded as "Gillick competent" and the judge was wholly right in so finding in relation to R.

Lord Donaldson MR indicated that "*Gillick* competency" is an important starting point in ascertaining the capacity of a minor. However, as far as the capacity of an incompetent minor is concerned, the refusal of consent does not prevent the doctor from obtaining consent from another competent authority. Furthermore, Lord Donaldson MR held that 'the court in exercise of its wardship or statutory jurisdiction has power to override the decisions of a "*Gillick* competent" child as

much as those of parents or guardians'[258]. This position was affirmed in the case of *Re W* (a minor) (medical treatment). Lord Donaldson MR in *Re W* held that 'a minor of any age who is "*Gillick* competent" in the context of the particular treatment has a right to consent to that treatment, which again cannot be overridden by those with parental responsibility for the minor, [but], it can, be overridden by the court'[259]. A possible distinction is that *Gillick v West Norfolk and Wisbech Area Health Authority* did not deal with issues relating to the inherent jurisdiction of the court.

From the analysis of the above cases, it is evident in the English jurisdiction that the "*Gillick* competency" standard is applicable as far as a minor's consent to medical treatment is concerned. However, this standard is modified in its application to an incompetent minor's refusal to medical treatment. The cases of *Re R* and *Re W* have modified the application of this standard and held that a "*Gillick* competent" child's refusal to treatment can be overridden by another competent authority. In *Re R* the child's refusal to medical treatment was overridden by those with parental responsibility whereas in *Re W* the child's refusal to medical treatment was overridden by the court.

The position in relation to a minor with mental disability was discussed in the Australian case of *Department of Health and Community Services v JWB and SMB* (Marion's Case) (1992) 175 CLR 218.

The facts of the case are as follows:[260]

> The patient, a minor, 14-year-female was suffering from severe mental retardation with deafness and epilepsy. She was not capable of looking after herself. Her parents applied to the Family Court of Australia for an order authorizing hysterectomy and ovarienectomy. A hysterectomy was

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[258] Above n 257, 603.
[259] Above n 164, 639.
[260] *Department of Health and Community Services v JWB and SMB* (Marion's Case) (1992) 175 CLR 218.

proposed to prevent pregnancy and menstruation, whereas an ovarienectomy was proposed to stabilize hormonal fluxes.

Mason CJ, Dawson, Toohey and Gaudron JJ in a joint judgment noted at 237:

> *The House of Lords decision in Gillick v West Norfolk AHA is of persuasive authority… A minor is, according to this principle, capable of giving informed consent when he or she "achieves" a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. This approach, though lacking the certainty of a fixed age rule, accords with experience and with psychology. It should be followed in this country as part of the common law.*

And at 239:

> *It is important to stress that it cannot be presumed that an intellectually disabled child is, by virtue of his or her disability, incapable of giving consent to treatment.*

And at 253:

> *The decision to sterilize a minor in circumstances such as the present falls outside the ordinary scope of parental powers and therefore outside the scope of the powers, rights and duties of a guardian under s. 63E (1) of the Family Law Act. This is not a case where sterilization is an incidental result of surgery performed to cure a disease or correct some malfunction. Court authorization in the present case is required.*
>
> *One more thing should be said about the basis upon which we have concluded that sterilization is a special case with respect to parental powers. As we have indicated, the conclusion relies on a fundamental right to personal inviolability existing in the common law… as well as on the practical exigencies accompanying this kind of decision.*

Mason CJ, Dawson, Toohey and Gaudron JJ in a joint judgment endorsed the applicability of "*Gillick* competency" standard as part of the Australian common law. It was the judge's view that the authorization of a court is required before a child can lawfully be sterilized and the factors that contribute towards this view include: (i) the emphasis that 'the courts will ensure the protection of the best interests of a child'[261], (ii) 'sterilization is an irreversible procedure and the consequences of a wrong decision is particularly grave[262], (iii) 'the requirement of a court authorization ensures a hearing from those with intellectual disability and from those with experience of the long term social and psychological effects of sterilization'[263], (iv) 'the court ensures that the best interests of the child prevails when taking the views of family members into account'[264]

In South Australia, section 12 of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) stipulates that:

> *A medical practitioner may administer medical treatment to a child if—*
>
> *(a) the parent or guardian consents; or*
>
> *(b) the child consents and—*
>
> *(i) the medical practitioner who is to administer the treatment is of the opinion that the child is capable of understanding the nature, consequences and risks of the treatment and that the treatment is in the best interest of the child's health and well-being; and*
>
> (ii) *that opinion is supported by the written opinion of at least one other medical practitioner who personally examines the child before the treatment is commenced.*

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[261] Above n 260, 249.
[262] Above n 260, 250.
[263] Above n 260, 251.
[264] Above n 260, 252.

This section is based on the "*Gillick* competency" standards as formulated in the English case of *Gillick v West Norfolk and Wisbech Area Health Authority* and approved in the Australian case of *Department of Health and Community Services v JWB and SMB* (Marion's Case).

In Australia, the final decision pertaining to the medical treatment of a child in certain situations rests not with the parents but with either:

- The Supreme Court of the State;
- The State Guardianship Tribunal/Board; or
- The Family Court of Australia.

(iii) <u>The scope of parental power</u>

The capacity of the parents to consent to the medical treatment of their child was discussed in the English case of *Gillick v West Norfolk and Wisbech Area Health Authority*.

Lord Scarman in a majority judgment noted at 420:

> *Parental rights clearly do exist, and they do not wholly disappear until the age of majority. Parental rights relate to both the person and the property of the child, care and control of the person and guardianship of the property of the child.*
>
> *The principle of the law, as I shall endeavour to show, is that parental rights are derived from parental duty and exist only as long as they are needed for the protection of the person and property of the child. The principle has been subjected to certain age limits set by statute for certain purposes; and in some cases the courts have declared an age of discretion at which a child acquires before the age of majority the right*

> *to make his (or her) own decision… It is abundantly clear that the law recognises that there is a right and a duty of parents to determine whether or not to seek medical advice in respect of their child, and, having received advice, to give or withhold consent to medical treatment.*

And at 421-422:

> *The law relating to parent and child is concerned with the problems of the growth and maturity of the human personality… The underlying principle of the law was exposed by Blackstone and can be seen to have been acknowledged in the case law. It is that parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision.*

Lord Scarman indicated that the parents do have the capacity to give consent to medical treatment with respect to their child. However, in certain situations that capacity terminates when the child has sufficient understanding and intelligence to make his/her own decision about his/her choice of medical treatment. This view was approved in the Australian case of *Department of Health and Community Services v JWB and SMB* (Marion's Case).

In Fiji, a child remains under the total care and control of his parents until he attains the age of majority[265], which is 21 years, and that on attaining that age he is capable of making decision about himself. However, the customary practice in Fiji is that the duration of parental responsibility extends beyond the age of majority to such time till the child is unmarried and residing with the parents. This parental responsibility is limited in its scope when it comes to provision of consent to medical treatment. The age of majority is different from the age at which a child can give consent to medical treatment. This age of consent to

[265] This is the age at which an individual can marry and the age at which he/she can vote.

medical treatment is 18 years. In Fiji, the parental responsibility terminates when the child reaches the age of 18 and therefore the child is able to consent to his/her choice of medical treatment. Section 46 (1) of the *Family Law Act 2003* stipulates that each of the parents of a child who is under 18 years has parental responsibility for the child. Fiji is a signatory to the *United Nations Convention on the Rights of the Child* which states that a child is someone who has NOT attained the age of 18 years. Therefore, the position in Fiji is that a competent person 18 years or above is capable of deciding whether to give consent or refuse to give consent to the medical treatment.

(iv) <u>The Guardianship Scheme</u>

The guardianship legislation within certain jurisdictions provides for the appointment of the guardian. The guardian will act as substitute decision maker for an incompetent person. The issue of whether the guardian has the capacity to give consent to medical treatment on behalf of the incompetent person is resolved through the statutory provisions. The statute provides with whom the capacity to give consent to medical treatment rests.

In New South Wales, section 33A (4) of the *Guardianship Act 1987* (NSW) stipulates that:

> *Person responsible for another person. There is a hierarchy of persons from whom the "person responsible" for a person other than a child or a person in the care of the Director-General under section 13 is to be ascertained. That hierarchy is, in descending order:*
>
> 1. *the person's guardian, if the instrument of appointment includes the function of giving consent to medical or dental treatment;*

2. *the spouse of the person if the relationship between the person and the spouse is close and continuing, and the spouse is not a person under guardianship;*
3. *a person who has the care of the person;*
4. *a close friend or relative of the person.*

In Queensland, section 63 of the *Powers of Attorney Act 1998* (QLD) stipulates that:

> *For a health matter, an adult's statutory health attorney*[266] *is the first, in listed order, of the following people who is readily available and culturally appropriate to exercise power for the matter—*
>
> *a) a spouse of the adult if the relationship between the adult and the spouse is close and continuing;*
>
> *b) a person who is 18 years or more and who has the care of the adult and is not a paid carer for the adult*
>
> *c) a person who is 18 years or more and who is a close friend or relation of the adult and is not a paid carer for the adult.*

In South Australia, section 59 (2) of the *Guardianship and Administration Act 1993* (SA) stipulates that:

> *For the purposes of* subsection (1) *, the appropriate authority is—*
>
> *a) if a guardian has been appointed in respect of the person under any Act or law, his or her powers as guardian have not been limited so as to exclude the giving of such consent and he or she is available and is willing to make a decision as to consent—the guardian;*

[266] Section 62 of the *Powers of Attorney Act 1998* (QLD) stipulates that this Act authorizes a statutory health attorney for an adult's health matter to make any decision about the health matter that the adult could lawfully make if the adult had capacity for the matter and is exercisable during any or every period the adult has impaired capacity for the matter.

b) in any other case—

(i) a relative of the person; or

(ii) the Board, on application by—

(A) a relative of the person; or

(B) the medical practitioner, dentist or other health professional proposing to give the treatment; or

(C) any other person who the Board is satisfied has a proper interest in the matter.

And, section 61 (2) of the *Guardianship and Administration Act 1993* (SA) stipulates that:

The Board cannot consent to a sterilisation unless: -

(a) it is satisfied that it is therapeutically necessary for the sterilisation to be carried out on the person; or

(b) it is satisfied :-

(i) that there is no likelihood of the person acquiring at any time the capacity to give an effective consent; and

(ii) that the person is physically capable of procreation; and

(iii) that :-

(A) the person is, or is likely to be, sexually active, and there is no method of contraception that could, in all the circumstances, reasonably be expected to be successfully applied; or

(B) in the case of a woman, cessation of her menstrual cycle would be in her best interests and would be the only reasonably practicable way of dealing with the social, sanitary or other problems associated with her menstruation,

and has no knowledge of any refusal on the part of the person to consent to the carrying out of the sterilisation, being a refusal that was made by

the person while capable of giving effective consent and that was communicated by the person to a medical practitioner.

From the analysis of the above schemes, it is evident in the States of New South Wales, Queensland and South Australia in the Australian jurisdiction that a guardian has the capacity to consent to medical treatment on the behalf of an incompetent person. In New South Wales and Queensland, in the absence of the guardian, the authority is then vested with the spouse of an adult if the relationship between the adult and the spouse is close and continuing. However, in South Australia the authority is vested with the relative if there is no guardian. The above statute operates in the hierarchical order whereby authority is vested with the next responsible person in the absence of the guardian. Furthermore, Guardianship Boards have been established in South Australia to give authorization to the carrying out of sterilization procedure.

(v) The inherent jurisdiction of the court

In the United Kingdom, 'the High Court has jurisdiction to make declarations as to the best interests of an adult who lacks decision-making capacity'[267].

The United Kingdom *Practice note (Official Solicitor: Declaratory Proceedings: Medical and Welfare decisions for adults who lack capacity)*[268] provides directives on this inherent jurisdiction of the court:

The High Court (but not the County Court) has inherent jurisdiction to make decisions about the lawfulness of proposed medical treatment, or withdrawal of medical treatment, or as to welfare issues such as where someone should live or with whom have contact in respect of adults who

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[267] 'Practice note (Official Solicitor: Declaratory Proceedings: Medical and Welfare decisions for adults who lack capacity)' (2006) http://www.officialsolicitor.gov.uk/docs/PracNoteMedicalandWelfareDecisions.doc (Assesses 12 May 2009)
[268] Above n 267.

lack capacity to make such decisions for themselves. The jurisdiction is discretionary, and will be exercised whenever there is a serious justifiable issue requiring a decision by the court.
The proceedings in relation to adults are civil proceedings to which the Civil Procedure Rules 1998 ["CPR"] apply and should be brought in the Family Division.

These applications are invariably brought in the Family Division under Part 8 of the CPR. The claimant should file all the evidence with the claim form. The relief sought should include declarations as to the patient's lack of capacity, and as to what the Claimant asserts is lawful as being in the patient's best interests.

The evidence filed must deal with litigation capacity, decision making capacity and best interests.

Unless the matter requires an urgent substantive hearing, the claimant should fix a directions hearing. The court should, if appropriate, be asked to hold the directions hearing in private to protect the interests of the patient: CPR r 39.2(3) (d). The court will use the directions hearing to:

- *make orders where necessary to preserve the anonymity of the patient, family and other parties;*
- *set a timetable for the Official Solicitor to conduct enquiries, obtain expert evidence and file his statement or report;*
- *fix a further hearing, to serve either as a final hearing if the matter is unopposed or as a final directions hearing to fix a contested hearing.*

An application seeking the court's authorization must be made in the following situations:[269]

(a) where it is proposed to withdraw artificial nutrition and hydration from a patient in the permanent vegetative state: *Re Airedale NHS Trust -v- Bland* [1993] AC 789.

(b) the sterilization for contraceptive purposes of a person who cannot consent - *Re S (Sterilisation)* [2000] 2 FLR 389.

'The courts in the [United Kingdom] have identified four circumstances where the non-treatment of incompetent patients by doctors is legally acceptable:

- Inevitable death in the short term, whatever therapy is provided: *Re C* (adult: refusal to treatment);
- Firm diagnosis of persistent vegetative state: *Re Airedale NHS Trust -v- Bland*;
- Severe brain damage, although the person may not be dying or in severe pain: *Re J* [1990] All ER 930;
- Great pain and suffering, although not necessarily associated with a terminal condition, with the prospect of a demonstrably awful life: *Re B* [1981] 1 WLR 1421.' [270]

In the Australian jurisdiction, this inherent jurisdiction of the court was discussed in *Department of Health and Community Services v JWB and SMB* (Marion's Case).

Mason CJ, Dawson, Toohey and Gaudron JJ in a joint judgment noted at 256:

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[269] Above n 267.

[270] Australian Capital Territory Department of Justice and Community Safety, *Consenting to Treatment: Developing an A.C.T Legislative Framework for giving consent to providing, withholding or withdrawing Medical Treatment to an incompetent adult*, Discussion Paper 2007 http://www.jcs.act.gov.au/eLibrary/papers/consenting_to_treatment.pdf (Assessed 10 November 2008).

It seems clear that the 1983 amendments to the Family Law Act 1975 (Cth) were intended to, and did, confer jurisdiction on the Family Court similar to the parens patriae jurisdiction, without the formal incidents of one of the aspects of that jurisdiction, the jurisdiction to make a child a ward of the Court.

And at 261:

It is clear enough that a question of sterilization of a child of a marriage arises out of the marriage relationship and that the sterilization of a child arises from the custody or guardianship of a child. Therefore, jurisdiction to authorize sterilization is within the reach of the power of the Commonwealth.

And at 263:

For present purposes it is enough to say that an order of the Family Court authorizing a sterilization operation would emanate from a constitutionally valid Commonwealth law and that the order would have an effect, in conjunction with the relevant Territory legislation, which would remove the operation from the area of the criminal law.

Mason CJ, Dawson, Toohey and Gaudron JJ held that the Family Court of Australia has jurisdiction to authorize sterilization procedures in relation to minors. This jurisdiction is termed as the *parens patriae* jurisdiction.

This *parens patriae* jurisdiction was taken into consideration with respect to the States under the Commonwealth of Australia in the case of *P v P* [1994] 120 ALR 545.

The facts of the case are as follows:[271]

> The patient, P, a minor, 16-year-female was suffering from intellectual disability. The parents sought declarations from the court to authorize carrying out a sterilization procedure in P. The parents have no intention to apply to the Guardianship Board constituted under the *Guardianship Act 1987* (NSW) for its consent.

Mason CJ, Deane, Toohey, Gaudron and McHugh JJ in joint judgment noted at 557-558:

> *It is clear from Marion's case that, putting to one side the effect of any applicable State or Territory law, the welfare jurisdiction of the Family Court extends to authorizing or prohibiting medical or dental treatment of a child of a marriage both "in cases where parents have no power to consent [to such treatment], as well as cases in which they have the power". Indeed, that jurisdiction in relation to medical treatment of a child lies at, or close to, the heart of a welfare jurisdiction which is applicable to that child.*
>
> *The Supreme Court of New South Wales had, however, long been vested with a wide parens patriae or guardianship jurisdiction. Clearly enough, it was not the intention of the parliament, in conferring general welfare jurisdiction upon the Family Court in respect of children of a marriage, to cover the field and thereby deprive the State Supreme Court of any parens patriae or guardianship jurisdiction in respect of such children. Equally clearly, however, it was not the intention of the parliament to subordinate the jurisdiction conferred by it on the Family Court, being part of the judicial power of the Commonwealth, to that which was conferred by State law upon the State Supreme Court.*

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[271] *P v P* [1994] 120 ALR 545.

> *The intent of the parliament, confirmed by the subsequent cross-vesting legislation of 1987, was that both jurisdictions should exist concurrently. In the case of a conflict between orders made by the Family Court in the exercise of the jurisdiction conferred by the Family Law Act and orders made by the Supreme Court of New South Wales in the exercise of its jurisdiction, the orders made by the Family Court would necessarily prevail. The State law, whether statutory or inherited, which conferred the relevant jurisdiction upon the Supreme Court would, to the extent that it purportedly gave legal efficacy to an order which was inconsistent with an order of the Family Court, be rendered invalid by s 109 of the Constitution for the reason that it was "to that extent" inconsistent with the provisions of the Family Law Act giving legal efficacy to the order made by the Family Court.*

Mason CJ, Deane, Toohey, Gaudron and McHugh JJ held that the Family Court has jurisdiction to authorize sterilization procedures to be carried out in an incompetent minor in New South Wales. This jurisdiction came within the marriage power of the Commonwealth.

In Fiji, the inherent jurisdiction of the court was discussed in an adoption case of *Re N* (an infant) [1994] 40 FLR 35.
Justice Fatiaki in a single judgment noted at 37-38:

> *Lord Denning MR in In re L (an infant) (1968) P.D. 119 said of the inherent jurisdiction of the Court of Chancery in relation to infants at p. 156:*
>
> > *"… It derives from the right and duty of the Crown as parens patriae to take care of those who are not able to take care of themselves. The Crown delegated this power to the Lord Chancellor, who exercised it in his Court of Chancery… The*

> *Child was usually made a ward of court and thereafter no important step in the child's life could be taken without the Court's consent. But that was only machinery. Even if there was no property and the child was not a ward of Court nevertheless the Court of Chancery had power to interfere for the protection of the infant by making whatever order might be appropriate… This wide jurisdiction of the old Court of Chancery is now vested in the High Court of Justice and can be exercised by any judge of the High Court. As a matter of convenience, the jurisdiction is exercised by making the child a ward of court and putting it under the care of a judge of the Chancery Division. But that is only machinery. If a question arises as to the welfare of a child before any judge of the High Court, he can make such order as may be appropriate in the circumstances." (emphasis mine)*

In this latter regard it may be noted that Section 18 of the High Court Act (Cap 13) expressly gives the High Court:

> *"… all the jurisdiction, powers and authorities which are for the time being vested in or capable of being exercised by Her Majesty's High Court of Justice in England."*

Accordingly, I am satisfied that this Court through the above statutory provisions has power to exercise the prerogative of the Crown or State as parens patriae in relation to minors or infants. Furthermore that the exercise of that power may be effected through wardship proceedings instituted under Order 90 of the High Court Rules.

Justice Fatiaki held that the Court has inherent jurisdiction to make the child a ward of the State. This inherent jurisdiction is conferred through section 18 of the *High Court Act* [Cap 13] and Order 90 of the *High Court Rules*.[272] Section

[272] The Order 90 of the *High Court Rules* sets out the procedure to make a minor a ward of the court.

18 of the *High Court Act* [Cap 13] provides powers to the High Court of Fiji to exercise all the jurisdiction, powers and authorities which are for the time being vested in or capable of being exercised by Her Majesty's High Court of Justice in England. Justice Fatiaki referred to the inherent jurisdiction of the Court of Chancery in the English case of *Re L* and held that this inherent jurisdiction can be exercised in Fiji in relation to infants or minors pursuant to sections 18 and 20 of the *Supreme Court* (now *High Court*) *Act* [Cap 13].

This inherent jurisdiction of the court extends to cover consent to medical treatment in minors and was invoked in the unreported cases of *Attorney General of Fiji v Re (a minor) (blood transfusion)* Civil Action HBC No. 161 of 1998 and *The Medical Superintendent CWM Hospital & The Attorney General of Fiji v Aminiasi Ratu and Selaniete Tukane & Sera Rosi Ratu* HBM Action No. 82 of 2009.[273]

From the analysis of the above cases, it is evident that the Courts have *parens patriae* jurisdiction which can be invoked to give authorization to medical treatments in relation to minors and incompetent persons.

3.13 Consent to Specific Invasive Procedures[274]

3.131 Abortion

Abortion is the act of removing fetus from the uterus and in the process bringing an end to pregnancy. There are statutory provisions present in the legislation in some jurisdictions which specify abortion as a criminal offence.

[273] This case is discussed at section 3.132.
[274] Specific invasive procedures are those procedures which are irreversible and carry a gravity of consequences. For the purposes of this thesis, specific invasive procedures include sterilization, abortion, blood transfusion and electro-convulsive therapy ("ECT"). Sterilization is discussed in 3.10 & 3.12. ECT is discussed in 2.1 & 3.2.

The rights of patient's in regard to abortion was discussed in the English case of *Paton v Trustees of BPAS* [1978] 2 All ER 987.

The facts of the case are as follows:[275]

> The wife visited two registered medical practitioners about her pregnancy. The doctors were of the opinion that her continuance of pregnancy would involve risk of injury to her physical and mental health. The doctors issued the necessary certificates so that her pregnancy can be lawfully terminated pursuant to section 1 (a) of the *Abortion Act 1967*. Her husband did not want her to have an abortion and applied to the court for an injunction restraining her from causing or permitting an abortion to be carried out on her without his consent.

Sir George Baker P in a majority judgment noted at 990 - 991:

> *In my view, that in England and Wales, the foetus has no right of action, no right at all, until birth. The succession cases have been mentioned. There is no difference. From conception the child may have succession rights by what has been called a 'fictional construction' but the child must be subsequently born alive. See per Lord Russell of Killowen in Elliot v Joicey [1935] All ER 578 at 589. The husband's case must therefore depend on a right which he has himself.*
>
> *The husband, therefore, in my view, has no legal right enforceable at law or in equity to stop his wife having this abortion or to stop the doctors from carrying out the abortion.*

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[275] *Paton v Trustees of BPAS* [1978] 2 All ER 987.

Sir George Baker P held that the husband has no right to lawfully stop his wife from having a legal abortion.[276] This view was approved in a similar case of *C v S* [1987] 1 All ER 1230.

In the United Kingdom, section 1 (1) of the *Abortion Act 1967* (UK) stipulates that:

> *Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith—*
>
> *(a) that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; or*
> *(b) that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or*
> *(c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or*
> *(d) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.*

This section states that an abortion can be legally carried out if (i) the pregnancy has not exceeded its twenty-four weeks and (ii) its continuance would involve risk to the life of the pregnant woman.

[276] Above n 275, 991.

In South Australia, section 61 (3) of the *Guardianship and Administration Act 1993* (SA) stipulates that:

> *The Board cannot consent to a termination of pregnancy unless it is satisfied-*
>
> *a. that the carrying out of the termination would not constitute an offence under the Criminal Law Consolidation Act 1935 ; and*
>
> *b. that there is no likelihood of the woman acquiring the capacity to give an effective consent within the period that is reasonably available for the safe carrying out of the termination,*
>
> *and has no knowledge of any refusal on the part of the woman to consent to the termination, being a refusal that was made while capable of giving effective consent and that was communicated by her to a medical practitioner.*

This section authorizes the Board to give consent to termination of pregnancy provided that the Board is satisfied that it is not an offence under the *Criminal Law Consolidation Act 1935* (SA) and there is no likelihood of the woman acquiring the capacity to give consent.

Furthermore, section 82A of the *Criminal Law Consolidation Act 1935* (SA) stipulates that:

> *(1) Notwithstanding anything contained in section 81 or 82, but subject to this section, a person shall not be guilty of an offence under either of those sections—*
>
> *(a) if the pregnancy of a woman is terminated by a legally qualified medical practitioner in a case where he and one other legally*

qualified medical practitioner are of the opinion, formed in good faith after both have personally examined the woman—

(i) that the continuance of the pregnancy would involve greater risk to the life of the pregnant woman, or greater risk of injury to the physical or mental health of the pregnant woman, than if the pregnancy were terminated; or

(ii) that there is a substantial risk that, if the pregnancy were not terminated and the child were born to the pregnant woman, the child would suffer from such physical or mental abnormalities as to be seriously handicapped,

and where the treatment for the termination of the pregnancy is carried out in a hospital, or a hospital of a class, declared by regulation to be a prescribed hospital, or a hospital of a prescribed class, for the purposes of this section; or

(b) if the pregnancy of a woman is terminated by a legally qualified medical practitioner in a case where he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life, or to prevent grave injury to the physical or mental health, of the pregnant woman.

Accordingly, carrying out of an abortion in South Australia is a criminal offence. However, a medical practitioner will not be guilty of an offence if he/she carries out an abortion on a patient based on an opinion of another qualified medical practitioner and with the view that the continuance of pregnancy will involve risk to the life of the pregnant woman.

In Fiji, section 172 of the *Penal Code* [Cap 17] stipulates that:

Any person who, with intent to procure the miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatsoever, is guilty of a felony, and is liable to imprisonment for fourteen years.

Furthermore, section 173 of the said Act stipulates that:

Any woman who, being with child, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatsoever, or permits any such thing or means to be administered or used to her, is guilty of a felony, and is liable to imprisonment for seven years.

And section 221 of the said Act stipulates that:

(1) Any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother is guilty of the felony of child destruction, and is liable to imprisonment for life:

Provided that no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose of preserving the life of the mother.

(2) For the purposes of this section, evidence that a woman had at any material time been pregnant for a period of twenty-eight weeks or more shall be prima facie proof that she was at that time pregnant of a child capable of being born alive.

Accordingly, carrying out of an abortion in Fiji is a criminal offence. However, the medical practitioner is not guilty of an offence if the abortion is carried out in good

faith with the purpose of preserving the life of the mother. Furthermore, section 221 of the said Act states that after twenty-eight weeks of pregnancy, it is assumed that the child is capable of being born alive, however this section does not seem to prohibit abortions after that time if such an abortion is necessary for the purpose of preserving the life of the mother and the act was done in good faith.

From the analysis of the above, it is evident that abortion is a criminal offence. However, a medical practitioner is not guilty of an offence if he/she carries out the abortion in good faith based upon their expert opinion that the continuance of pregnancy will pose threat to the physical and mental health of the pregnant woman.

It is important to note that in the United Kingdom the period within which a legal abortion can be carried out is within twenty-four weeks of pregnancy whereas in Fiji the period specified in the *Penal Code* [Cap 17] states that a child is capable of being born alive if within twenty-eight weeks of pregnancy.

3.132 Blood Transfusion

Blood transfusion is the act of transferring a person's blood or blood products into the blood stream of another person. In certain situations the parents do not consent to blood transfusion in their child during medical treatment. This refusal is based on religious grounds.

The refusal of blood transfusion on religious grounds was taken into consideration in the English case of *Re S* (a minor) (medical treatment) [1993] 1 FLR 376.
The facts of the case are as follows:[277]

[277] Jo Bridgeman, *Parental responsibility, young children and health care law* (2007) at 143-144, http://books.google.com.fj/books?id=KUtS1XIec4EC&pg=PA143&lpg=PA143&dq=Re+S+(a+minor)+(medical+treatment)+%5B1993%5D+1+FLR+376&source=bl&ots=DHTMXR4_Oa&sig=lx4ccjgEK3rXGseqYxo6ziUX6hA&hl=en&ei=vUcLSvjTH5CKtAPXqcWFAw&sa=X&oi=book_result&ct=result&resnum=5 (Assessed 14 May 2009).

> The patient was a child of 4 ½ years suffering from T-cell leukaemia. Intensive Chemotherapy offered a 50 percent chance of cure which may involve blood transfusion. The patient's father had strong religious belief and refused to consent to the administration of blood products even if that resulted in the death of his son. The authorization of the court was sought to allow administration of blood products.

Justice Thorpe overruled the religious objections of the father regarding blood transfusion and granted the orders sought.[278] The parent's views were taken into consideration. However, Justice Thorpe was 'not prepared to allow those religious convictions to deny their child a 50% chance of survival and condemn him to inevitable and early death'[279]. Furthermore, Justice Thorpe 'also dismissed the argument that the child would suffer stress and problems in future from his parents' belief that his life was prolonged by an ungodly act since the fact that the responsibility for consent was taken from them by a judicial act would absolve their consciences.[280]

This view was approved in the case of *Re O* (a minor) (medical treatment) [1993] 2 FLR 149.

The facts of the case are as follows:[281]

> The patient was a baby girl born over twelve weeks premature. Premature babies are given blood transfusion if their red blood cell levels fall. The consultant pediatrician had exhausted all alternatives and was of the opinion that the patient's red blood cell count had fallen so low that her vital organs were in danger. The parents were Jehovah's Witness and refused to consent

[278] Kee PT, 'Refusal to consent on religious grounds', (1995) *Murdoch University Electronic Journal of Law* http://www.murdoch.edu.au/elaw/issues/v2n2/kee221.html (Assessed 1 August 2008).
[279] Above n 278.
[280] Above n 278.
[281] Above n 277.

to the administration of blood products. The authorization of the court was sought to allow administration of blood products.

'The court overruled the refusal of the Jehovah's Witness parents to blood transfusions because there was need for a blood transfusion in the circumstances, the child's chances of survival were good and the alternatives to blood had been attempted without success.'[282]

From the analysis of the above cases, it is evident that the court has power to overrule the parent's refusal of administration of blood products to their child. This is 'based on three main principles: (a) the child's interests and those of the state outweigh parental rights to refuse medical treatment (b) parental rights do not give parents life and death authority over their children and (c) parents do not have an absolute right to refuse medical treatment for their children based on their religious beliefs if that refusal is regarded as unreasonable'[283]. It is important to note that the doctors attempted to make use of alternative products to blood and when they have exhausted all alternatives then the consent from the court was sought.

In the Australian case of *Dalton v Skuthorpe* (unreported decision of Supreme Court of New South Wales, 17 Nov. 1992, No. 5094 of 1992), 'the court granted an order authorizing the medical staff of the relevant hospital to carry out medical treatment including a blood transfusion, believed to be necessary to save the child's life or to prevent serious damage to the child's health including the alleviation of appreciable risk of serious damage to the child's health'[284].

In the Australian Capital Territory, section 23 (3) & (4) of the *Transplantation and Anatomy Act 1978* (ACT)[285] stipulates that:

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[282] Above n 278.

[283] S Woolley, 'Jehovah's Witness in emergency department: What are their rights?' (2005) *Emergency Medical Journal* http://emj.bmj.com/cgi/content/full/22/12/869 (Assessed 14 May 2009).

[284] Above n 278.

[285] This Act has been amended by the *Transplantation and Anatomy Amendment Act 2000* (ACT). However the above provision remains the same.

3) Subject to subsection (4), a medical practitioner may administer a blood transfusion to a child without the consent of a parent of the child or a person having authority to consent to the administration of the transfusion if—

(a) that medical practitioner and at least 1 other medical practitioner are of the opinion that the child is in danger of dying and that the administration of a blood transfusion to the child is the best means of preventing the death of the child; and

(b) the firstmentioned medical practitioner has satisfied himself or herself that the blood to be transfused is compatible with the blood of the child.

(4) A medical practitioner is not entitled to administer a blood transfusion to a child under subsection (3) unless—

(a) a parent of the child, or a person having authority to consent to the administration of the transfusion, on being asked to consent to the administration of the transfusion, has failed to give his or her consent; or

(b) the medical practitioner is of the opinion that, in the circumstances, it is not practicable to delay the administration of the transfusion until the consent of a parent of the child or a person having authority to consent to the administration of the transfusion can be obtained.

This section of the Act authorizes the medical practitioner to carry out blood transfusion in a child based upon similar opinion of another medical practitioner provided that the transfusion is done (i) to save the life of the child and the treating doctor and another doctor are of the opinion that the blood to be transfused is compatible with the blood of the child and (ii) it is not practicable to delay the administration of the transfusion until the consent of a parent of the child or a person having authority to consent to the administration of the transfusion can be obtained.

From the analysis of the above, it is evident that the courts in Australia have the power to authorize administration of blood transfusion. However, in the Australian Capital Territory, section 23 (3) & (4) of the *Transplantation and Anatomy Act 1978* (ACT) states that medical practitioners can conduct blood transfusion without the consent of the parents provided that (i) another medical practitioner is of the same opinion (ii) the transfusion is done to save the life of the child (iii) the blood to be transfused is compatible with blood of the child and (iv) it is not practicable to delay the administration of transfusion.

In Fiji, the courts have the inherent jurisdiction to consent to the administration of blood transfusion in an infant. This inherent jurisdiction was invoked in the unreported case of *Re (a minor) (blood transfusion) and* the 2009 case of *The Medical Superintendent CWM Hospital & The Attorney General of Fiji v Aminiasi Ratu and Selaniete Tukane & Sera Rosi Ratu.* In both the cases, the parents were Jehovah's Witness and refused to consent to the administration of blood transfusion during a medical surgery of the child. The Attorney General's Chambers sought declaration from the court authorizing blood transfusion. The courts exercised *parens patriae* jurisdiction and granted the orders sought on basis of preserving the life of the child.

Part 1V: Drafting a Model Medical Consent Bill

4.1 Essence of Codification

Gibbon in his book on *The history of the decline and fall of the Roman Empire*[286] declared that 'the discretion of the judge is the first engine of tyranny'[287]. Judges are the custodians for making and determining the common law principles in regards to consent to medical treatment. This common law principle has to some extent now been overtaken by statute law.

Lindsay Farmer in an article on *Reconstructing the English Codification Debate: The Criminal Law Commissioners*[288] noted at paragraph 2:

> *The common law is uncodifiable; a code sacrifices the flexibility of the common law, trapping its reasoning within rigid conceptual confines; a code offers clarity where the common law is vague and uncertain; the law of the legislator is better or worse, or more democratic, or more out of touch, than judge-made law; the code offers accessibility, where common law is accessible only to those trained in the artificial reasoning of the law. The code, in short, offers system, the common law adaptability.*

In the New Zealand Medical Practitioners Disciplinary Tribunal decision of *Director of Proceedings v Frizelle*[289], Professor Frizelle noted at 25:

> *The increasing legalisation of medical practice has led to concerns by medical practitioners about their ability to deal with these unrealistic expectations. One*

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[286] Edward Gibbon, *The history of the decline and fall of the Roman Empire* http://www.fullbooks.com/The-History-of-The-Decline-and-Fall-of-thex31199.html (Assessed 15 April 2009).
[287] Above n 286.
[288] Lindsay Farmer, 'Reconstructing the English Codification Debate: The Criminal Law Commissioners 1833-45' http://www.historycooperative.org/journals/1hr/18.2/farmer.html (Assessed 15 April 2009).
[289] *Director of Proceedings v Frizelle* (Medical Practitioners Disciplinary Tribunal: Decision No. 219/02/94D; 3 December 2002.) http://www.mpdt.org.nz/decisionsorders/decisions/0294dfindings.PDF (Assessed 15 April 2009).

can always add something more to a consultation. Doctors have to be careful to ensure that they are realistic about the information that should be given in regard to a procedure. One can almost always in retrospect add something, or clarify something. With the aid of retrospective analysis, when a patient does have an unexpected complication or problem, one will always wish that the possibility had been discussed. Even if it had, however, there is increasing evidence to show that there is a good chance that the patient or their family member would not remember it anyway. The aim of the increased legalisation is to protect the patient, and there have undoubtedly been times when it is apparent that it is required. We must be careful, though, not to lose touch with the real world; we are real people and the world we live in is not perfect. The legalisation of what should be a medical act has increased to such an extent that it is almost impossible to fulfill the requirements of informed consent (or it is almost always possible to pick holes in it).

Codification provides the means by which common law principles are embodied into statutory provisions. The statutory provisions upon enactment enable the information to be available to the public at large. It provides accessibility with certainty and creates awareness as well as aiding in its implementation, henceforth, equipping the public with sufficient information to safeguard their interests pertaining to the law of consent to medical treatment.

4.11 Accessibility and Awareness

Legislation provides an easy access to legal information for the public to view. The availability of laws in a codified form makes it much easier to refer to particular areas of law. It also provides a precise guideline on what actions to pursue in terms of statutory relief. Statute dealing with medical consent will be easier to access and the public will be aware of its provisions and applications.

4.12 Certainty and Enforcement

Unlike common law, legislation provides certainty in its provisions. There is a gray area of concern pertaining to the law of consent to medical treatment. In Fiji, issues such as medical consent, age of consent and types of consent are not covered in statutes therefore common law or judge-made law is relied upon. This is not the case in other jurisdictions. For example, the State of South Australia has enacted *Consent to Medical Treatment and Palliative Care Act 1995* (SA) and the Ontario Province of Canada has enacted the *Health Care Consent Act 1996* (Ontario) dealing with the area of law concerning consent to medical treatment. The common law principles tend to deal with possible circumstances as and when they arise. Legislation on the other hand provides a framework for how laws are to be dealt with and its enforceability. It provides a better understanding and set of statutory guidelines on the rights of patients and thus creates provision of health care services of acceptable standard and quality.

The laws of a country should articulate and reflect the norms, values and cultures of its society. A statutory approach to the law of consent to medical treatment will not only improve the provision of health care services but also motivate the health care professionals to practice skillfully. The reason being that the public will be aware about their rights in respect to medical treatments and the relevant statutory provisions can be relied upon to safeguard their interests in relation to making their own decision about the choice of medical treatment they want without being influenced by the physician or third party. Codification will provide a clear direction to the physician on what path to pursue in emergency situations where consent might not be available or where the patient is a minor. Statute will provide clarity in its application and thus will further enhance and govern the practice of general medicine.

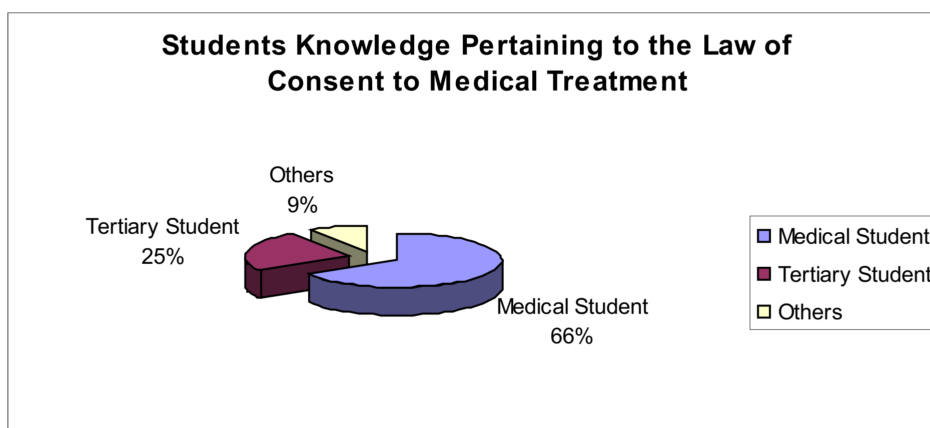
4.2 Public Opinion

4.21 Research Methodology

A Questionnaire was handed out to the general public to evaluate their understanding on the law concerning consent to medical treatment and their views on the need for legislation in this particular area. The target groups were medical students, tertiary students, professionals (doctors, lawyers, teachers and accountants)

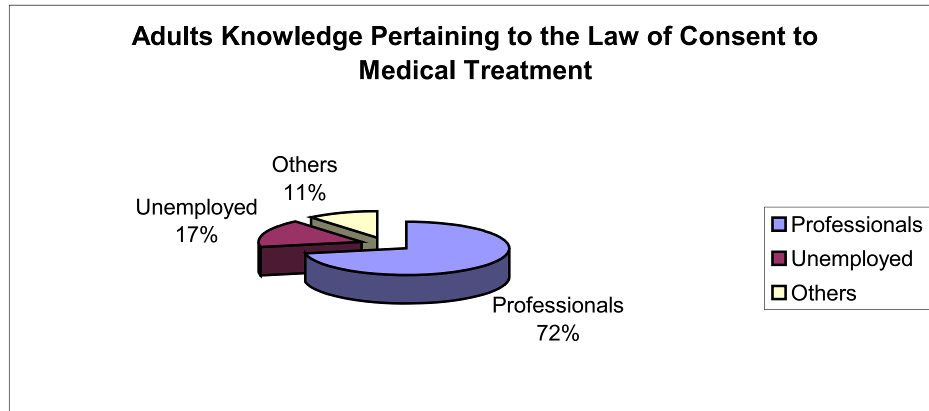
and the unemployed. The survey was mainly carried out in the Suva and Nausori area. A set of Questionnaires was also given to the Year 2 Student Nurses and Postgraduate Student Nurses at Fiji School of Nursing. Another set of Questionnaires was given to the general public at random in the Suva – Nausori corridor. The data collected reflected the view that there was lack of awareness pertaining to the law of consent to medical treatment and the general public was not familiar with the consent process.

4.22 Graphical Analysis on Knowledge Pertaining to the Law of Consent to Medical Treatment[290]



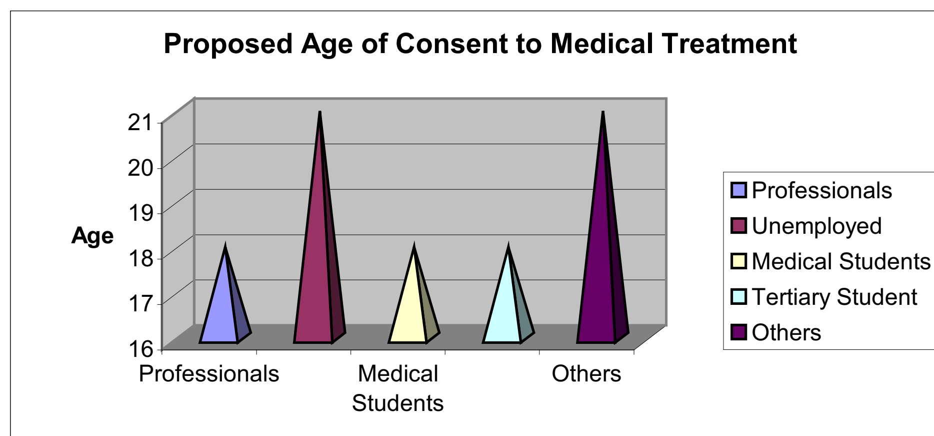
A total of 100 responses were collected from students who were in the age range of 18 – 25 years old. The question asked was 'Are you familiar with the law governing the concept of medical consent to treatment?'[291] The data reflected the view that approximately 66% of the medical students during the course of their studies have come across subjects that made reference to consent to medical treatment. However, the information imparted is very limited and does not go into detail explaining about the important pillars of consent to medical treatment. Approximately 25% of Tertiary Students mainly Science and Law students were familiar with the concept of consent to medical treatment. However, they also lacked in depth knowledge in the subject area.

[290] The set of Questionnaires is annexed in Appendix 1 & 2.
[291] This is Question 1 on *Interview Questionnaire for Students* annexed in Appendix 1.



A total of 100 responses were collected from adults who were 21 years and above. The question asked was 'Are you familiar with the law governing the concept of medical consent to treatment?'[292] The data reflected the view that only those who were in association with the medical fraternity either through work and professionals (consisting of Doctors, Teachers, Lawyers and Accountants) were familiar with the concept of consent to medical treatment. However, they only had basic knowledge and lacked information on types and exceptions to consent. About 17% of the unemployed had some knowledge about consent to medical treatment. However, the information they had was provided to them by the physicians upon consultation. The data reflected the view that there is lack of awareness in the subject area.

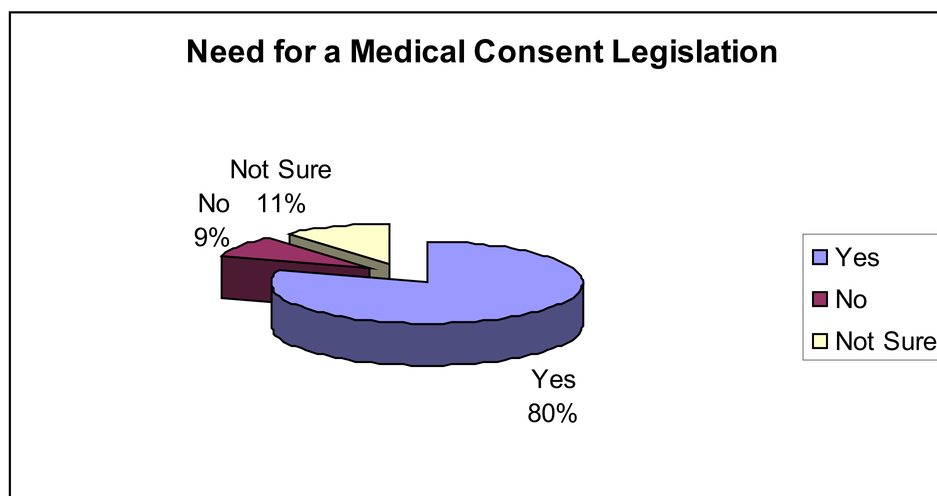
4.23 Graphical Analysis on Proposed Age of Consent to Medical Treatment[293]



[292] This is Question 1 on *Interview Questionnaire for Adults* annexed in Appendix 2.
[293] The set of Questionnaires is annexed in Appendix 1 & 2.

A total of 200 responses were collected out of which 100 responses were from students and 100 were from adults. The question asked was 'In your opinion, what should be the legal Age of Consent to medical treatment?'[294] There was confusion as most of them were not sure whether 18 or 21 was the age at which valid consent could be given. However, most of them did propose that 18 should be the age at which valid consent must be sought. In their perspective, an 18 year old does have the understanding and capability to make decision about the choice of medical treatment or procedure they wish to undergo. The data reflected the view that the Professionals, Medical Students and Tertiary Students proposed 18 as the legal age of consent to medical treatment whereas the unemployed proposed 21 as the age of consent. Upon analyzing their reasons for the proposed age of consent, it was found that the level of education played an important part in their decision-making capability. Those with Tertiary qualifications (such as Doctors, Teachers, Lawyers and Accountants) and the Medical and Tertiary Students were of the view that they were capable of making decision about the choice of medical treatment at the age of 18 and they should be consulted on what should or should not be done to their body rather than taking consent from a guardian.

4.24 Graphical Analysis on the Need for Legislation[295]



[294] This is Question 3 on *Interview Questionnaires* annexed in Appendix 1 & 2.
[295] The set of Questionnaire is annexed in Appendix 1 & 2. A total of 200 responses were received out of which 100 responses were from students and 100 were from adults.

A total of 200 responses were collected out of which 160 were of the view that there must be a legislation to protect and safeguard the interests of individuals pertaining to consent to medical treatment. The question asked was 'In your opinion, should there be a legislation dealing with the law of medical consent?'[296] It was a common view that there was no means of ascertaining sufficient information on laws pertaining to consent to medical treatment. The only means was through what the physician informed them, but then again there was uncertainty in the information that was disclosed. Legislation in the said area of law will provide accurate information and enable individuals to better equip themselves with knowledge on consent to medical treatment. In the view of the physicians, legislation in the said area will also provide safeguards to the practice of medicine.

4.3 Drafting Instructions

It is of essence that policy papers pertaining to the law of consent to medical treatment be formulated and thus these policy papers will form the basis of drafting instructions upon which statutory provisions can be drafted.

According to the Fiji Cabinet Memorandum on *Statutory Programme*[297] dated March 2007, the steps for drafting legislation are:[298]

> *Legislation is a manifestation of a Government policy. The first step is policy formulation and development. The Ministries are responsible for policy formulation and development. Clear and well developed and detailed policy determines the quality of legislation. More often than not, if policies are not clearly articulated then the resultant law will not be clear in intention and purpose.*

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[296] This is Question 4 on *Interview Questionnaires* annexed in Appendix 1 & 2.
[297] Fiji Cabinet Memorandum, *Statutory Programme*, (26th March 2007).
[298] Above n 297, [2.0].

The second step is the approval of the policy and the legislative framework by Cabinet. This step allows Cabinet to control and prioritize its statutory programme.

The third step is the drafting process. The drafting process commences only after endorsement of policy and the legislative framework. The drafting stage involves the analysis of the policy, the proposed legislative framework, undertaking of research, meetings and discussion and actual drafting of statutory provisions.

The fourth step involves consultation process to be undertaken by the Ministry. Basically, internal consultation with the Government will continue throughout the process of policy formulation. In most cases, stakeholders or interest groups are also involved during the internal consultation process. The final step involves scrutiny and approval of legislation.

This Cabinet paper states that the process for formulating legislation includes:

(i) formulation of draft policy by relevant Ministry,
(ii) approval of policy and legislative framework by Cabinet,
(iii) drafting and
(iv) scrutinizing the draft Bill.

The model *Medical Consent Bill* will have emphasis on the common law principles discussed in this paper and also reflect on the statutory provisions in other jurisdictions. However, it is of essence that the codification is adaptable and able to be implemented in accordance with the standards in Fiji.

4.4 Drafting a Model Medical Consent Bill

MODEL MEDICAL CONSENT BILL

TABLE OF PROVISIONS

SECTION

1. Short Title
2. Interpretation
3. Application
4. Age of consent
5. Competency
6. Consent to medical treatment
7. Timeframe of consent validity
8. Revocation of consent
9. Appointment of guardian
10. Termination of guardianship
11. Powers of the Court
12. Emergency medical treatment
13. Protection from Liability
14. Penalty
15. Power to make regulations

Schedule 1: Guardianship Form

Schedule 2: Termination of Guardianship Form

Schedule 3: Consent Form

Schedule 4: Revocation of Consent Form

AN ACT RELATING TO THE RIGHT OF AN INDIVIDUAL TO CONSENT TO A MEDICAL TREATMENT OR PROCEDURE

Short title

1. This Act may be cited as the *Medical Consent Act*.

Interpretation

2. In this Act, unless the context otherwise requires –

incompetent means an individual under mental disability;
medical practitioner means a person who is registered under the *Fiji Medical and Dental Practitioners Act* Cap 255;
ministry means Ministry for Health;
non-therapeutic means without medical necessity;
parent includes a person *in loco parentis*;
specific invasive procedure includes those procedures which are irreversible and carry a gravity of consequences. For the purposes of this Act, a specific invasive procedure means a sterilization, abortion, blood transfusion and electro-convulsive therapy ("ECT").

Application

3. This Act does not apply to medical procedures conducted for the purposes of research and does not authorize a medical practitioner to carry out medical procedures for the purpose of causing or assisting death and/or assisting suicide.

Age of consent

4. Unless the contrary is demonstrated, a person of or over 18 years of age is capable of making decision about his or her own medical treatment.

Competency[299]

5. Notwithstanding section 4, a person is capable of making a decision about his or her own medical treatment provided that he or she demonstrates the ability to –
   (a) understand and communicate the information given by the medical practitioner about the administration of the medical treatment; and
   (b) make a balanced judgment about undergoing that treatment on the basis of the information provided; and
   (c) make the decision.

Consent to medical treatment[300]

6. (1) Consent can be expressed or implied.
   (2) Express consent can be verbal or in writing.
   (3) If the consent to medical treatment is in writing, then the individual provides valid consent to the medical practitioner if –
      (a) the consent relates to the proposed medical treatment, and
      (b) the consent is given voluntarily, and
      (c) the consent is not obtained by fraud or misrepresentation,
      (d) the individual is capable of making a decision about whether to give or refuse consent to the proposed medical treatment, and
      (e) the medical practitioner gives the individual the information a reasonable person in the position of the patient would require to understand about the proposed medical treatment and to make a decision, including information about –
         (i) the condition for which the medical treatment is proposed, and
         (ii) the nature of the proposed medical treatment, and
         (iii) the risks and benefits of the proposed medical treatment, and

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[299] This section is based on the three-stage test formulated by Justice Thorpe in *Re C* (Adult: Refusal to Treatment) [1994] 1 All ER 819.
[300] This section is based on the principles formulated in section 6 of the *Health Care (Consent) and Care Facility (Admission) Act 1996* [Cap 181](British Columbia)

(iv) alternative methods of medical treatment, and

(f) the individual has an opportunity to ask questions and receive answers about the proposed medical treatment.

(4) Consent is implied when a competent patient willingly submits to the medical procedure.

Timeframe of consent validity

7. A written consent will be valid for a period of 12 months unless otherwise revoked under section 8.

Revocation of consent

8. A patient may at anytime revoke either orally or in writing, his or her consent to administration of medical treatment.

Appointment of guardian

9. (1) This section does not apply to specific invasive procedures.

(2) A competent adult may at anytime –

(a) appoint a guardian to make decisions about his or her medical treatment in the event that the competent adult becomes incompetent; provided that-

(i) the appointee must be or over 18 years of age; and

(ii) the appointment must be made in the relevant form and duly executed and witnessed;

(b) In the event the competent adult becomes incompetent and there has been no guardian appointed, the medical practitioner may seek consent from the following in ascending order depending on availability –

(i) parents;

(ii) the spouse of the person if the relationship between the person and the spouse is close and continuing;

(iii) a person who has the care of the individual;

(iv) a relative of the individual.

(3) A medical practitioner may administer medical treatment to a person under the age of 18 years if the parent or the guardian consents.

Termination of Guardianship

10. An authorization to Guardianship terminates, if it is –

(a) revoked by the individual; or

(b) revoked by the guardian; or

(c) revoked by the court.

Powers of the Court[301]

11. The Court has powers to –

(a) confirm, cancel, vary or reverse the decision of the guardian;

(b) revoke the authority of guardianship;

(c) substitute another person for the person named to give consent or directions;

(d) make decisions about non-therapeutic specific invasive procedures;

(e) give consent to administration of medical treatment in an incompetent person;

(f) give consent to administration of medical treatment in a minor;

(g) make an order and grant such relief as the judge considers appropriate.

Emergency medical treatment

[301] This section is based on the principles formulated in section 6 of the *Medical Consent Act 1989* [Cap 279] (Nova Scotia).

12. A medical practitioner may administer medical treatment to an individual without consent, if in the opinion of the medical practitioner –
    (a) there is an emergency; and
    (b) the individual's life is at risk.

Protection from liability[302]

13. A medical practitioner responsible for the treatment and care of an individual, incurs no civil or criminal liability for an act or omission done –
    (a) with the consent of the patient or the patient's guardian or without consent but in accordance with an authority conferred by this Act or any other Act; and
    (b) in good faith; and
    (c) in accordance with proper professional standards of medical practice; and
    (d) in order to preserve or improve the quality of life of the patient.

Penalty

14. A breach of this Act shall amount to disciplinary action under the *Medical and Dental Practitioners Act* [Cap 255].

Power to make regulations

16. The Minister may make regulations generally for the purpose of carrying out or giving effect to the provisions of this Act.

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[302] This section is based on the principles formulated in section 16 of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA).

Schedule 1: *Guardianship Form*

Form Number ____________

I ______________________________ of ____________________________

National Health Card No: ______________________ hereby appoint

____________________ of _______________________________ National Health

Card No: _______________

As my guardian and duly authorize him/her to make decision about any medical treatment or procedure carried out on me in the circumstance whereby I am unable to make any such decision due to my incapability.

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Name/Signature Date

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Guardian Name/Signature Date

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Witness Name/ Signature Date

Schedule 2: *Termination of Guardianship Form*

Form Number __________________

I ______________________________ of ____________________________ National Health Card No: ______________________ hereby terminate the appointment made on Form Number __________________of ____________________________ of _______________________________ National Health Card No: _______________

As my guardian.

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Name/Signature Date

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Witness Name/ Signature Date

Schedule 3: Consent Form

Form Number ____________

I ______________________________ of ____________________________

National Health Card No: ______________________ hereby consent to the following medical treatment

____

The physician on or about _______________ (date) did explain to me as follows:

The Nature of the treatment

____

____

____

The Risks of the treatment

____

____

____

The Alternative methods of treatment

____

____

____

The Consequences of refusing treatment

____

____

____

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Name/Signature Date

Schedule 4: *Revocation of Consent Form*

Form Number ____________

I ______________________________ of ____________________________

National Health Card No: _________________ hereby revoke my consent to the following medical treatment _____________________________ (Form Number ___________)

The physician on or about _______________ (date) did explain to me as follows:

The Nature of the treatment

____

____

____

The Risks of the treatment

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____

____

The Alternative methods of treatment

____

____

____

The Consequences of refusing treatment

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____

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Name/Signature Date

CONCLUSION

This thesis concludes with a draft Bill adaptable to Fiji jurisdiction. This Bill includes provisions dealing with the area of law concerning consent to medical treatment which have been drawn from the common law and statutory approaches taken within United Kingdom, Australia, New Zealand and Canadian jurisdictions.

The area of law concerning medical negligence is indeed very broad. This thesis draws on the United Kingdom, Australia, New Zealand, Canada and Fiji jurisdictions in respect to the law concerning consent to medical treatment and failure to warn of risks and alternatives to treatments.

Some of the limitations are indicted below:

Firstly, reference was only made to the States of New South Wales, Queensland, South Australia and the Australian Capital Territory in respect to the Australian jurisdiction and reliance was only on the province of Ontario in respect to the Canadian jurisdiction. Each jurisdiction has its own laws dealing with consent to medical treatment and failure to warn of risks and alternatives to treatments. However some States, Territories or Provinces in these various jurisdictions have pro-active policies and laws dealing with consent to medical treatment which have not been analyzed due to the lack of resources. The availability of limited resources has contributed to analyzing only the primary materials that have been available at the University of the South Pacific Library and the Library of the Attorney General's Chambers in the Fiji Islands.

Secondly, the purpose behind this thesis wasn't to make reference to each and every State, Territory or Province but to make reference to only a few States, Territories or Provinces and draw their common law and statutory approaches into the draft Bill.

This thesis was an excellent learning process and the research conducted herein will provide a framework for better governance in the area of general medicine. This thesis

has drawn my attention to the laws concerning consent to medical treatment and failure to warn of risks and alternatives to treatments within United Kingdom, Australia, New Zealand, Canada and Fiji jurisdictions. There were a few limitations whilst undertaking the task however the learning experience gained from this thesis has been indeed worthwhile.

APPENDICES

Appendix 1: Interview Questionnaire for Students

Appendix 2: Interview Questionnaire for Adults

Appendix 3: General Consent Form used in Fiji

Appendix 4: Consent Form for Surgery used in Fiji

Appendix 1: Interview Questionnaire for Students

A Statutory Approach to Law of Medical Consent: Drafting a Model Medical Consent Bill

Masters of Law Thesis Nakil N Prasad Research Questionnaire: Students

Name: ____________________(Optional) School:________________
Year : ____________________ Age:________________

---

1. Are you familiar with the law governing the concept of medical consent to treatment?

   Yes ☐ Please explain how you came to know about law of medical consent.

   ____

   ____

   ____

   No ☐ Please provide reasons.

   ____

   ____

   ____

2. What is the legal Age of Consent to medical treatment?

   ____

3. In your opinion, what should be the legal Age of Consent to medical treatment? Why?

   ____

   ____

4. In your opinion should there be a legislation dealing with the law of medical consent?

   Yes ☐ Please provide reasons.

   ____

   ____

   ____

   No ☐ Please provide reasons.

   ____

   ____

Appendix 2: Interview Questionnaire for Adults

A Statutory Approach to Law of Medical Consent: Drafting a Model Medical Consent Bill

Masters of Law Thesis Nakil N Prasad Research Questionnaire: Adults

Name: ___________________(Optional) Occupation:_______________
Employer : _______________________ Age:________________

---

1. Are you familiar with the law governing the concept of medical consent to treatment?

   Yes ☐ Please explain how you came to know about law of medical consent.

   ____
   ____
   ____

   No ☐ Please provide reasons.

   ____
   ____
   ____

2. What is the legal Age of Consent to medical treatment?

   ____

3. In your opinion, what should be the legal Age of Consent to medical treatment? Why?

   ____
   ____

4. In your opinion should there be a legislation dealing with the law of medical consent?

   Yes ☐ Please provide reasons.

   ____
   ____
   ____

   No ☐ Please provide reasons.

   ____
   ____

Appendix 3: General Consent Form Used in Fiji

CONSENT BY PATIENT

____ Hospital

I ____________________________________ of ______________________________________

hereby consent to undergo the operation of _______________________________________ the nature and effect of which have been explained to me by Dr./Mr. ______________________________________

I also consent to such further or alternative operative measures as may be found to be necessary during the course of the operation and to the administration of a local or other anaesthetic for any of these purposes.

No assurance has been given to me that the operation will be performed by a particular surgeon.

Date _____________________________ (Signed) _____________________________

I confirm that I have explained to the patient the nature and effect of this operation.

Date _____________________________ (Signed) _____________________________

CONSENT BY PARENT OR GUARDIAN

____ Hospital

I ____________________________________ of ______________________________________

hereby consent to the submission of _______________________________________ to the operation of ____, the nature and effect of which have been explained to me by Dr./Mr. ____

I also consent to such further or alternative operative measures as may be found to be necessary during the course of the operation and to the administration of a local or other anaesthetic for any of these purposes.

No assurance has been given to me that the operation will be performed by a particular surgeon.

Date _____________________________ (Signed) _____________________________

I confirm that I have explained to the patient the nature and effect of this operation.

Date _____________________________ (Signed) _____________________________

REMOVAL

I hereby take full responsibility for removing ______________________________ from Hospital against advice.

Signature _________________ Witness ______________________ Date ____/___/20____

I give my consent for Autopsy in this case.

Signature _________________ Witness ______________________ Date ____/___/20____

Appendix 4: Consent Form for Surgery Used in Fiji

Central Eastern Health Service
INFORMED CONSENT FORM FOR SURGERY

PERSONAL INFORMATION

NAME:	**NATIONAL HEALTH NO./FOLDER NO.**		
ADDRESS:	**MO I/C**		
KORO DINA	**DOB**	**SEX**	**AGE**
CONSENT FOR MEDICAL PROCEDURE/TREATMENT	**ADMISSION DATE**		

For patients over 14 years able to consent and for parents on behalf of children. Not for Guardianship Act purpose.

MEDICAL ADVICE Part A

Dr. ___________________________ and I have discussed my/ ___________________________
Name of Doctor Name of Child
condition and the various ways in which it may be treated. The doctor has recommended: …………………………………………………………………………………………………….…….
Name of Procedure

The doctor has also told me that

- An Anaesthetic, Medicine or blood transfusion may be needed and these may have some risks;
- Additional procedures or treatments may be needed if the doctor finds something unexpected;
- Complications may occur;
- The procedure/ treatment may not give the expected result even though the procedure/ treatment is carried out with due professional care.

I understand that undergoing the procedure/ treatment carries risks. I have had the opportunity to ask questions. I am satisfied with the explanation and the answers to my questions.
(I have not been told that the procedure /treatment will be done by a particular doctor)

……………………………… ……… …………………………………
Signature of Patient/ Guardian Date Print Name of Patient/ Guardian

I Dr. __________________________ have informed this patient/ guardian as detailed above, including the nature, likely results and relevant foreseeable risks of the recommended procedure/treatment.

____
Signature of Medical Practitioner

PATIENT CONSENT Part B

I consent to the procedure/ treatment described above for me/ for ……………………….
Name of Patient
Except that I do not agree to having ……………………………………………………
Name of Procedure/ Treatment
I accept the risks involved in the procedure/ treatment.
I also consent to Anaesthetics, Medicines or other treatments which could be related to this procedure/ treatment.
If the doctor finds something unexpected during the procedure/ treatment, I consent to the doctor treating it also. I consent to blood transfusion if needed.

……………………………… ……… …………………………………
Signature of Patient/ Guardian Date Print Name of Patient/ Guardian

……………………………………………………………………………….……………………..
Address

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