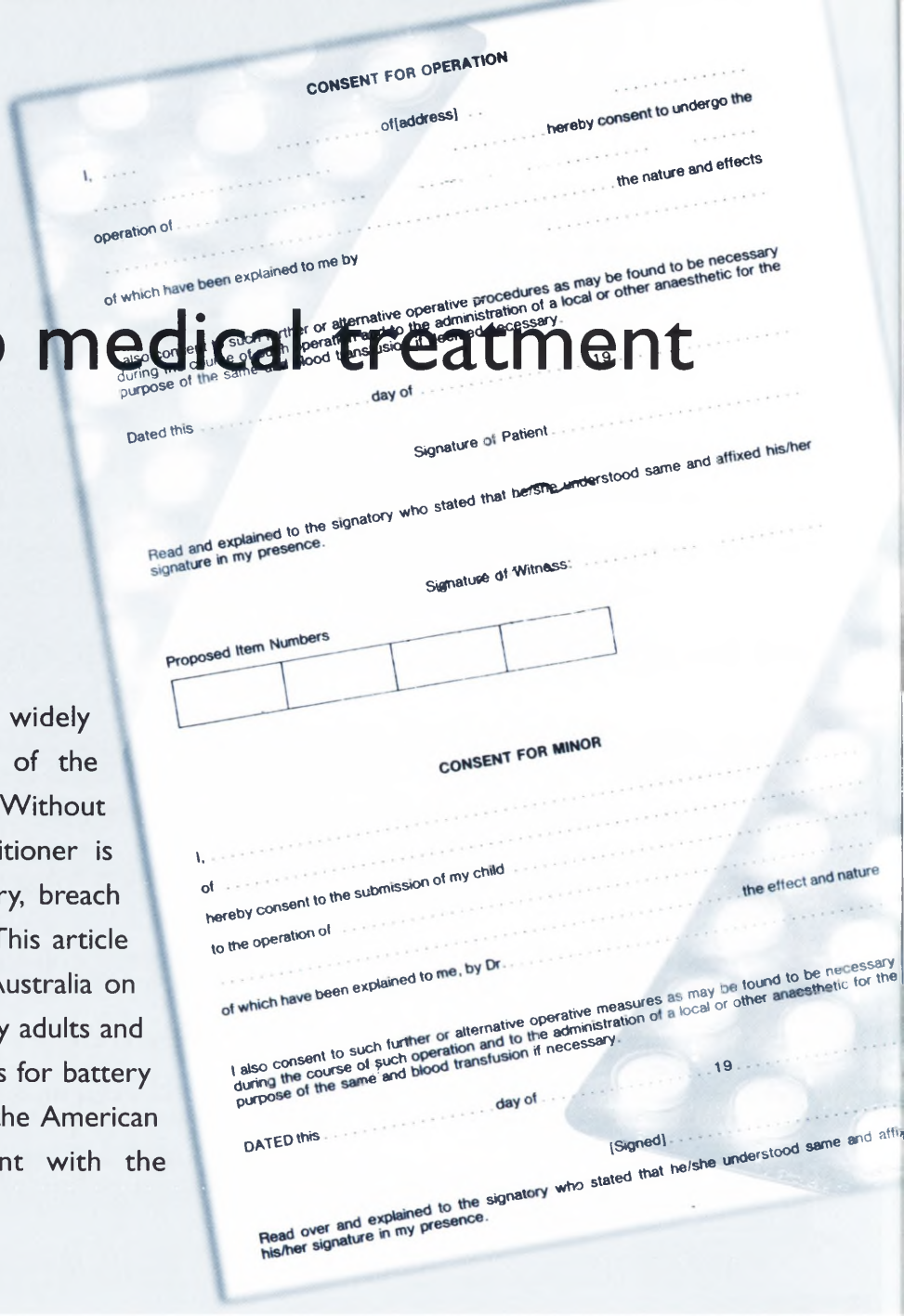
PENELOPE WATSON, NSW

Consent *to* medical treatment


CONSENT FOR OPERATION

I, ... of [address] ..... hereby consent to undergo the operation of ..... the nature and effects of which have been explained to me by .....

I also consent to such further or alternative operative procedures as may be found to be necessary during the course of such operation and to the administration of a local or other anaesthetic for the purpose of the same and blood transfusion if necessary.

Dated this ..... day of 19

Signature of Patient .....

Read and explained to the signatory who stated that he/she understood same and affixed his/her signature in my presence.

Signature of Witness: .....

Proposed Item Numbers

CONSENT FOR MINOR

I, ...

of .....

hereby consent to the submission of my child .....

to the operation of ..... the effect and nature

of which have been explained to me, by Dr .....

I also consent to such further or alternative operative measures as may be found to be necessary during the course of such operation and to the administration of a local or other anaesthetic for the purpose of the same and blood transfusion if necessary.

DATED this ..... day of ..... 19 .....

[Signed] .....

Read over and explained to the signatory who stated that he/she understood same and affix his/her signature in my presence.

Consent to treatment is widely regarded as the cornerstone of the doctor-patient relationship.[1] Without valid consent, a medical practitioner is vulnerable to actions for battery, breach of contract, and/or negligence. This article examines the common law in Australia on consent to medical treatment by adults and minors in the context of actions for battery and negligence, and contrasts the American doctrine of informed consent with the position adopted in Australia.

'In the absence of consent all, or almost all, medical treatment and all surgical treatment of an adult is unlawful, however beneficial such treatment might be. This is incontestable.'[2]

Various competing principles of the philosophy of health care, or bioethics, underpin both common law and statute law in the medical arena. Any examination of the laws regulating medical practice must be conducted in the context of these bioethical principles, and the relative importance attached to each. The legal requirement of consent is founded upon a patient's right to self determination, or autonomy, a right which has long been recognised. As Cardozo J said in 1914, '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.'[3] In *Rogers v Whitaker*[4], the High Court described as 'the paramount consideration' the view that 'a person is entitled to make his own decisions about his life.'[5] Kantians,[6] some pluralist deontologists, and even many Utilitarians[7] support the centrality of autonomy. Other major bioethical principles include justice, non-maleficence ('do no harm'), and beneficence (production of the best medical result for the patient).[8]

Autonomy and beneficence are the dominant focus for modern western medicine, both playing a role in the

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'There is a strong, though not absolute, presumption in favour of treatment which will prolong the life of the child.'

Australian Medical Association's Code of Ethics. In some cases, a choice has to be made between the two principles, for example those involving refusal of treatment, such as Jehovah's Witnesses refusing life-saving blood transfusions on religious grounds. The law has adopted the clear view in such situations that patient autonomy prevails, even where a refusal of treatment will or may result in the death of the patient.[9] For example, in *Malette v Shulman*[10], the plaintiff was awarded $20,000 in battery for mental distress following a blood transfusion which had probably saved her life. She had been admitted to hospital unconscious after a serious car accident, but was carrying a card identifying her as a Jehovah's Witness who did not consent to administration of blood products. Her adult daughter had also specifically refused a transfusion on the mother's behalf. Of course, on similar facts without the presence of written instructions or any information as to the patient's wishes, the principle of beneficence would operate. In that event, the doctor may lawfully treat the patient, and has a duty to do so, in accordance with the doctor's view of what constitutes the best interests of the patient, without risking battery.[11] Alternatively, the defence of necessity would apply.

The 'only possible qualification' to the rule of adult self determination, apart from statutory overriding, is where the death of a viable foetus might also result.[12] Even in that situation, the English Court of Appeal in *R v Collins*[13] said recently:

'How can a forced invasion of a competent adult's body against her will even for the most laudable of motives (the preservation of life) be ordered without irremediably damaging the principle of self determination?'

From this perspective, the importance of consent cannot be overstated.

ELEMENTS OF A VALID CONSENT: VOLITION, INFORMATION AND CAPACITY

Consent may be express or implied, oral or written. It will often be implied from conduct[14] but, especially in the case of surgery or more serious treatment, it is standard practice for patients to sign a written consent form. This is not conclusive evidence of consent.[14] A valid consent consists of three elements: volition, information and capacity.[15] The patient must be old enough and have sufficient intelligence or rationality to consent, and the decision must be freely made and based on adequate information. The law has swung markedly in the patient's favour in its interpretation of voluntariness in modern times. In one case in 1881[16], a servant suspected of being pregnant was forced by her employer to undergo a pregnancy test, which was held not to amount to a battery. In contrast, a patient in 1964 who was persuaded while under sedation to agree to a type of anaesthetic which she had previously refused, was held not to have consented. In the latter case, the Canadian court said that a doctor:

'may not overrule his patient and submit him to risks that he is unwilling and in fact has refused to accept. And if he does so and damages result, he will be responsible without proof of negligence or want of skill...The vital question is whether or not [the patient] gave a full and free consent...[and] the burden of proof rests on [the] doctor.'[17]

This is, of course, because the action will be maintainable as trespass, since 'any touching of another's body is, in the absence of lawful excuse, capable of amounting to a battery'[18] and in Canada as well as Australia[19], the onus of proof to negative consent rests on the defendant. However, it is clear that the opposite is true in England. *Freeman v The Home Office (No 2)*[20], concerning forcible administration of prescribed drugs to a prisoner, established that 'the essence of battery is the unconsented to intrusion of another's bodily integrity'. Therefore, the plaintiff had to prove lack of consent. The argument that the plaintiff's situation as a prisoner made it impossible for him to genuinely exercise freedom of choice was rejected.

The second limb of consent is the requirement of information. Other than in South Australia[21], there is no legislative obligation to provide information to adults of normal capacity, although there are comprehensive guidelines published by the National Health and Medical Research Council (NHMRC).[22] Australia[23], England[24] and Canada[25] have rejected the United States' doctrine of 'informed consent' which requires 'knowledge of all the facts relevant to the formation of an intelligent and informed consent.'[26] Instead, in Australia, doctors need only inform patients 'in broad terms' of the nature of the procedure.[27] The doctor's duty 'adequately to warn' of risks was judged according to the *Bolam*[28] standard prior to *Rogers v Whitaker*[29], but since *Rogers*, the doctor 'has a duty to warn a patient of a material risk inherent in the proposed treatment' subject to therapeutic privilege.[30] That duty 'is premised on the notion of the patient's autonomy.'[31] The High Court in *Rogers* approved the view in *Chatterton v Gerson* and *Ellis v Wallsend District Hospital*[32], that:

'It is well established in major common law jurisdictions that failure to fully inform of risks does not vitiate consent provided that the patient is informed in broad terms of the procedure intended. Actions for failure to warn of risks lie in negligence, not trespass.'

The example given in *Chatterton v Gerson*, of a boy being mistakenly circumcised when admitted to hospital for a tonsillectomy, would found a cause of action in battery, as would any taint of bad faith or fraud in withholding ▶

information. This is similar to the approach adopted by the criminal law in situations where sexual assault is represented as medical treatment, thus vitiating consent.[33] In general, however, courts take the view that '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.'[34] The distinction needs to be clearly drawn, therefore, between risks which are incidental or collateral to the particular treatment, thus constituting a failure to warn leading to liability in negligence, and those which go to 'the basic nature and character of the operation or the procedure'[35], negativing consent and grounding an action in trespass.

D v S[36] is an example of a case in which the plaintiff succeeded in both negligence and trespass because the failure to warn was substantial enough to vitiate consent. In that case, the plaintiff was prescribed oestrogen tablets after a hysterectomy, which increased her bust size, causing neck and back pain. She was advised to have a reduction mammoplasty. She was left with ongoing severe pain, 'grossly disfiguring' scarring, her nipples had been unevenly relocated and one breast was larger than the other. She developed a drinking problem and her marriage broke down. The doctor had not told her full or accurate details of the procedure beforehand, and she had the impression that the procedure was a very minor operation. Matheson J held that 'if she had been told [the details of the operation] she would not have consented...and...her consent was not a true consent'.

The third element of consent is capacity. For most adults there is a presumption of competence, but this is not so for minors and mentally ill or intellectually impaired adults. The leading case at common law on children's capacity to consent is the House of Lords decision in *Gillick v West Norfolk Area Health Authority*[37], approved in Australia in *Secretary, Department of Health and Community Services v JWB and SMB*[38] (Marion's case). Relevant legislation in New South Wales includes the *Guardianship Act* 1987, the *Mental Health Act* 1990, the *Children and Young Persons (Care and Protection) Act* 1998, and the *Minors (Property and Contracts) Act* 1970.

In *Gillick*, the mother of a sixteen-year-old sued because her daughter had been prescribed contraception without parental consent. The House of Lords rejected the 'inflexibility and rigidity' of a fixed age limit, holding:

'as a matter of law [that] the parental right to determine whether or not their minor child below the age of sixteen 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.'[39]

Gillick has been criticised because it 'ignores [the] realities of everyday med-

ical practice. It is doubtful if many adults would satisfy the criteria – let alone young people', and places too much emphasis on the 'necessarily subjective judgement of individual doctors'.[40] Lord Scarman's test that a child must 'understand fully what is proposed' also seems at variance with the requirement to inform 'in broad terms' laid down in *Chatterton v Gerson*.[41] However, the High Court felt that *Gillick* 'accords with experience and psychology [and] should be followed in this country as part of the common law.'[42]

Marion's case concerned a fourteen-year-old girl suffering from mental retardation, severe deafness, epilepsy and behavioural problems, and unable to care for herself. Her parents applied to the Family Court of Australia for an order authorising performance of a hysterectomy and ovariectomy on Marion, or alternatively a declaration that it was lawful for them to consent to the procedures. On appeal, the High Court said:

'In the case of medical treatment of those who cannot consent because of incapacity due to minority, the automatic reference point is the minor's parent or other guardian. Parental consent, when effective, is itself an exception to the need for personal consent to medical treatment. The sources of parental power, including the power to consent...are the *Family Law Act* 1975 (Cth), the common law and the [Criminal] Code.'[43]

The court went on to hold that 'it cannot be presumed that an intellectually disabled child is, by virtue of his or her disability, incapable of giving consent to medical treatment...[as capacity] depends on the rate of development of each individual'.

There are situations relating to non-therapeutic[44] procedures in which even a parent may not consent on behalf of a disabled child, especially those affecting reproductive capacity. In relation to sterilisation, the High Court in Marion's case said that such a decision 'should not come within the ordinary scope of parental power to consent...Court authorisation is necessary [as] a procedural safeguard', because of the significant risk of making the wrong decision, and because of the gravity of the consequences of an error. Power to make such orders derives from the *parens patriae* jurisdiction of the court, as discussed below. The court may authorise the procedure but this is not a giving of consent.[45]

In cases of refusal of beneficial treatment, *Gillick* does not allow minors to override parental consent.[46] Where children are too young to consent, and parental consent has been refused, courts generally take the opposite view to that for adults, applying the beneficence concept of the 'best interests' of the child. There is a strong, though not absolute, presumption in favour of treatment which will prolong the life of the child. In a recent New Zealand case, *Healthcare Otago Ltd v Williams-Holloway*[47], which generated intense media interest, the parents of a four-year-old cancer patient decided not to subject the child, Liam, to any further agonising chemotherapy, and to pursue alternative types of treatment. The Family Court placed Liam under the guardianship of the court and granted consent for medical treatment, including chemotherapy, to be administered. The parents went into hiding with their child and the court discharged his parents of custody, placing him in the custody of the Director-General of Social Welfare, and issuing a warrant for Liam's apprehension for treatment. Ultimately, all orders were withdrawn on the application of the healthcare authority. Such cases starkly contrast the competing interests of family privacy and parental autonomy on the one hand, with the state's right or duty to protect vulnerable members of the community on the other.

STATUTORY PROVISIONS AND *PARENS PATRIAE* JURISDICTION

The common law in New South Wales and South Australia on child consent to treatment has been modified by statute. In New South Wales, the *Minors (Property and Contracts) Act* 1970 (NSW), section 49(1) provides that ▶

consent given by a parent of a minor aged less that sixteen has effect for the purposes of an action for assault and battery as if that consent had been given by the adult child, and s 49 (2) deems consent given by minors aged fourteen and upwards to have effect as if given by the child at age twenty-one.

These provisions were adopted, in identical terms, from a recommendation of the 1969 Law Reform Commission of New South Wales Report. In its report, the Commission made it clear that the provision was intended to apply to assault only, not negligence, and that it was not limited to contract. For New South Wales purposes, *Gillick* should be regarded as conferring power to consent on young persons, whereas section 49 of the Act relates to a restriction of their right to sue for trespass. Section 175 of the *Children and Young Persons (Care and Protection) Act* 1998 (NSW) defines a range of 'special medical treatments' for which the consent of the Guardianship Tribunal must be obtained for minors under the age of sixteen, including sterilisation and long-term use of certain contraceptive drugs. This is in keeping with Marion's case.

Section 174 provides that emergency medical treatment may be given without the consent of the child or his or her parents, if it is needed to preserve the life or health of the child. All states have legislative provisions similar to the *Guardianship Act* 1987 (NSW), which confers jurisdiction on the Guardianship Tribunal to protect the person and property of certain categories of people unable to protect themselves, including those with disabilities. Section 37 authorises treatment without consent if it is necessary to save life or prevent serious damage to the patient's health, or prevent suffering, except in the case of 'special treatment'.

Section 183 (1) of the *Mental Health Act* 1990 (NSW) sets out the requirements for obtaining informed consent to treatment, requiring a 'fair explanation' and a 'full description...without exaggeration or concealment...of discomforts and risks...[as well as] benefits. Notice must be given that the person 'is free to refuse or to withdraw consent', and legal representation is permitted. Section 155 deals with consent to psychosurgery, and s 204 with 'special medical treatment.' Emergency treatment is covered in s 201.

The Guardianship Tribunal has powers under the Act, including determining whether a person is capable of giving informed consent, and whether the administration of certain treatment 'is reasonable and proper and is necessary and desirable for the safety or welfare of the person' where consent has been refused (for example, s188 (2) (b)). Legislation regulates the giving of consent by adults and minors to the donation of human tissue for transplantation – in New South Wales the *Human Tissue Act* 1983 (NSW). This is based on

a report of the Australian Law Reform Commission[48], and imposes stringent conditions for the validity of consent.

Even in relation to persons with capacity to consent, statutory powers may override the normal legal preference for self determination. In the case of asylum seekers on hunger strikes for example, force feeding is permitted under Regulation 5.35 of the Migration Regulations under the Migration Act, which authorises medical treatment where a detainee refuses consent. Similarly, s 16(2) of the *Prisons Act* 1952 (NSW) was interpreted in *Schneidas v Corrective Services Commission & Others*[49] as authorising force feeding as medical treatment.

The Supreme Court has a *parens patriae* jurisdiction which is essentially protective in nature.[50] By resort to this jurisdiction, the court is empowered to give consent on behalf of minors or other persons unable to consent. This could be because of disability, but could also be for other reasons, such as unconsciousness. For example, in *MAW v Western Sydney Area Health Service*[51] a court order was sought to permit the taking of sperm from a comatose patient, for purposes of impregnating his wife after his death. In refusing the order, O'Keefe J said the *parens patriae* jurisdiction:

'does not extend to authorising a non therapeutic surgical procedure of the kind contemplated...[which] is not a procedure that will preserve the life of the patient ...[nor] which will safeguard, secure or promote...the physical or mental wellbeing of the patient...recognition of yet another special case [in addition to sterilisation in *Marion's case*, would] operate to weaken the general principle of inviolability of the body of the individual.'[52]

CONCLUSION

In conclusion, the law on consent to medical treatment is inextricably entwined with ethical considerations based on competing views about patient autonomy and welfare. Valid consent to medical treatment is essential to negate actions in trespass, but information 'in broad terms' is all that is necessary to defend negligence suits. Persons not competent to consent, through mental infirmity or minority, are accorded substantial rights which are protected at common law as well as legislatively. PL

Endnotes:

1 Jones M, *Medical Negligence*, 1991, Sweet & Maxwell, London, p. 200; Madden W, 'Tort Reform and Medical Liability,' (Dec 2002) 54 *Plaintiff* p. 14.

2 *In re F* [1990] 2 AC 1, at 12, per Lord Donaldson MR.

3 *Schloendorff v Society of New York Hospital* [1914] 211 NY 125, at 126.

4 [1992] 175 CLR 479.

5 Quoting and approving *F v R*, [1983] 33 SASR 189 at 193.

6 see TL Beauchamp and JF Childress, *Principles of Biomedical Ethics*, 2nd ed, 1983, New York, Oxford University Press, at 60.

7 see John Stuart Mill, *On Liberty*, 1859.

8 Devereux J, *Medical Law: Text, Cases and Materials*, 1997, Cavendish Publishing, Sydney, at 3.

9 see for example *In re T (Adult: Refusal of Treatment)* [1993] Fam 95 (CA); *Airedale v NHS Trust v Bland* [1993] AC 789; *St George'sNHS Trust v S* [1998] 3 All ER 673; *Malette v Schulman* [1990] 67 DLR (4th) 321.

10 above n 14.

11 *Wilson v Pringle* [1987] QB 237; see *Northbridge v Central Sydney Area Health Service* [2000] NSW SC 1241, at par [23], per O'Keefe J.

12 *In re T* per Lord Donaldson MR at 102. See also *In re S (Adult: Refusal of Treatment)* [1993] Fam 123 and *St George's Healthcare NHS Trust v S* [1999] Fam 26 (CA).

13 [1998] 3 WLR 936, per Judge LJ at 957.

14 *Re T (Adult: Refusal of Treatment)* [1993] Fam 95 at 102.

15 *Chatterton v Gerson* [1981] QB 432.

16 Jones M, *Medical Negligence*, supra n 3, at 51.

17 *Latter v Braddell* (18810 50 LJQB 448.

18 *Beausoleil v Sisters of Charity* [1964] 19 DLR (2d) 65, per Casey J.

20 *In re F (Mental Patient: Sterilisation);* [1990] 2 AC 1 at 73 per Lord Goff of Chiveley.

21 *Hart v Herron* (1980) [1984] Aust Torts Reps 80 – 201 (NSW SC); *Sibley v Milutinovic* ((1990) Aust Torts Reps 81 – 013 (ACT SC).

22 [1984] 1 QB 524.

23 *Consent to Medical Treatment and Palliative Care Act* 1995 (S Aust).

24 *General Guidelines for Medical Practitioners on Providing Information to Patients*, 1993.

25 *Rogers v Whitaker.*

26 *Sidaway v Governors of Bethlem Royal Hospital* [1985] AC 871, at 881.

27 *Reibl v Hughes* [1980] 2 SCR 880.

28 *Canterbury v Spence* [1972] 464 F 2d 772.

29 *Chatterton v Gerson* above n 19, per Bristow J.

30 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

31 supra n 6.

32 But see *Review of the Law of Negligence* (the Ipp Report), above n 4, and the *Civil Liability Amendment (Personal Responsibility) Bill* 2002 (NSW), and discussion of both in W Madden, above n 5.

33 *Tan v Benkovic* [2000] NSW CA 295, per Mason P at par [29].

34 Unreported, Supreme Court of NSW, 16 Sept 1988, per Cole J.

35 for example, *R v Williams* [1923] 1 KB 340; *R v Rosinski* [1824] 1 Lew CC 11; *R v Maurantonia* [1968] 1 OR 145.

36 supra n 13.

37 Somerville MA," Structuring the Issues in Informed Consent' (1981) *26 McGill Law Journal* 740, quoted in Devereux, supra n 12.

38 [1981] LS (SA) JS 405.

39 [1986] 1 AC 112.

40 [1992] 175 CLR 218.

41 supra n 22, per Lord Fraser.

42 Queensland Law Reform Commission 'Consent to Medical Treatment of Young People' Discussion Paper No 44, May 1995, at 56.

43 Devereux, above n 12, at 84.

44 Marion's case, at 86.

45 at 86.

46 *Re Jane* [1989] FLC 92-007, at 260; *Re B (a minor)* [1988] AC 199, at 211 (HL).

47 at 87.

48 *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 at 84 (CA).

49 [1999] NZFLR 812.

50 *Human Tissue Transplants*, ALRC No 7, 1977.

51 Unreported, NSW SC Administrative Law Division, Lee J No 4082 of 1983, 8 April 1983 (BC 8300004).

51 Marion's case.

52 [2000] NSW SC 358.

53 at paras [41] and [42].