

NSW Law Reform Commission REPORT 62 (1989) - INFORMED DECISIONS ABOUT MEDICAL PROCEDURES

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List of Recommendations

Recommendation 1

The common law standard of reasonable care which now applies to the provision of information to patients concerning a proposed treatment or medical procedure should not be replaced by a statutory standard.

Recommendation 2

Guidelines for the provision of information to patients concerning a proposed treatment or procedure should be formulated by the National Health and Medical Research Council.

(a) In considering the guidelines, the Council should take account of the following matters:

(i) the need in each case for doctors to pay attention to the patient's circumstances;

(ii) the fact that less information may be necessary if the doctor is clearly satisfied on reasonable grounds, and after reasonably careful investigation, that the patient understands and agrees to the proposed procedure, but does not want more information; or that the patient's health or welfare might be seriously harmed if the patient were more fully informed about the procedure; or that an emergency exists in which it is not possible to give the information;

(b) The appropriate authorities should consider including discussion of the guidelines in medical courses as a means of educating medical students in relation to giving patients appropriate information. The guidelines might also be referred to in quality assurance and peer review programs, hospital protocols and hospital accreditation reviews. Patient education and self-help programs might also inform patients about the guidelines to help patients communicate with their doctors.

Recommendation 3

Legislation should be enacted requiring that, in an action for professional negligence, the guidelines will be admissible in evidence and the courts will consider them in deciding whether a doctor has acted reasonably in relation to the provision of information.

Recommendation 4

The *Medical Practitioners Act 1970 (Vic)*, the *Medical Practitioners Act 1938 (NSW)* and the *Medical Practitioners Registration Act 1930 (ACT)* should each be amended to provide specifically that professional misconduct includes a failure to provide adequate information to a patient concerning a proposed treatment or medical procedure.

1. Introduction

Background to reference

Recent changes in community and medical practice

1. During the last 20 years, there has been a gradual but significant change in the relationships between doctor and patient. Communication between doctors and patients has improved. There has been growing recognition, particularly among younger doctors, that patients should have more information about their condition, prognosis and treatment options and that patients are entitled to make decisions about their treatment.

2. Many factors have contributed to this change. One influence is the social movement towards greater community participation in decision-making. Another lies in advances in medical science and clinical practice. Procedures for the diagnosis and treatment of illness have become more complex. There is not necessarily a clear-cut choice about the most appropriate treatment. Instead, there may be a range of options, each with its advantages and disadvantages. Treatment, whether medical or surgical, and some diagnostic tests, carry risks. Consequently, there is a greater need for patients to be informed about the potential risks so that they can decide whether to undertake the test, treatment or operation. The public is now much better informed about medical diagnosis and procedures. Media publicity and discussion of medical issues is widespread. People have become more critical and questioning about their own illnesses and their doctor's advice.

3. These changes in the community have already led to substantial changes in Government policy and legislation. In Victoria, for example, the Government's *Social Justice Strategy* emphasises the need for individuals to be involved in decision-making that affects their lives. Freedom of information legislation, both Commonwealth and State, acknowledges and secures to a distinct degree the right of individuals to be given information relevant to them and to decisions that affect them. Victorian statutes such as *the Health Services (Conciliation and Review) Act 1987*, the *Medical Treatment Act 1988* and the *Health Services Act 1988* recognise that patients are entitled to be provided with information. One of the responsibilities of the Health Services Commissioner is to deal with complaints alleging lack of information. *The Medical Practitioners Act 1970* is also under review. In New South Wales, legislative and administrative action has been taken with the establishment of a Complaints Unit within the Department of Health and a review in 1987 of the complaints and disciplinary provisions of the *Medical Practitioners Act 1938* (NSW).

4. As the movement towards greater patient involvement in decision making has occurred, doctors have gradually changed the way in which they deal with patients. Although some doctors still believe that they should make decisions, many now give their patients more information and encourage them to decide for themselves about their treatment. However, despite this gradual change, communication problems remain between some doctors and their patients.¹ There are also differing perceptions within the medical profession about the need for information to be given and the problems associated with giving it.

Legal and practical problems

5. These problems have led to complaints and occasionally to legal action against doctors both in Australia and overseas. There have been few legal cases in Australia and patients have rarely been successful. Patients have alleged that their doctors were negligent in failing to give them adequate information about proposed medical procedures, especially about risks or possible complications involved. In one or two cases, it has even been alleged that the doctor gave so little information that the patient could not give an effective consent to the treatment or the operation in question and that there was therefore an assault on the patient. These cases have required judicial consideration of the nature and extent of information that doctors should give patients in relation to a proposed medical procedure.

Purpose and scope of this report

6. This report focuses on two major areas. The first is the legal principles determining liability of doctors on the ground of failure to give information to patients. This is an area in which doctors' and patients' interests and the

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interests of the community may have different emphases. Doctors' interests are in ensuring that legal standards are clear and can be complied with readily; patients' interests are in some form of redress where a particular doctor has not met the appropriate standards; the community interest is in ensuring that standards are sufficient to enable informed discussion and decision-making. This report considers whether the existing law strikes a fair balance between these interests. Also considered under this heading is the question of disciplinary actions against doctors who fail in some serious respect to meet the standard of practice expected by the community.

7. The second area concerns the ways in which the process of informing patients can be facilitated in practice. There need be no conflict between the interests of doctors and patients here. It is in the interest of both that the process of giving and receiving information is made as simple, efficient and reliable as possible. Doctors might be helped by guidelines setting out the information which should normally be given to patients who are considering a particular treatment or operation. Patients might be helped by the preparation and distribution of information sheets describing in simple terms the advantages and disadvantages of particular procedures. Where language difficulties exist, accredited interpreters could be used, whenever possible, to enhance communication.

8. This report is confined to situations where the patients are adult and are capable of making their own decisions. It does not deal with the more complex problems arising in relation to other patients, particularly children and those who are not able to make decisions for themselves by reason of some mental or physical disability. Those problems are not simply about communication. They raise legal issues about the person with whom the doctor should, or must, communicate.²

General principles underlying recommendations in this report

9. The general principles underlying the recommendations in this report are:

Doctors should respect the right of patients to make their own decisions about medical procedures, whatever the decision may be.

Doctors should so far as is reasonable give patients sufficient information concerning their condition to enable them to make an informed decision. This information should include options for treatment, including the likely result if the treatment is not undertaken, and any possible side-effects of treatment.

Medical education should include communication skills and relationship skills, to enhance the ability of doctors to give appropriate and understandable information.

The law should establish, or recognise, a standard for the giving of information which:

- is clear and reasonable;
- would so far as is reasonable enable patients to make an informed decision as to their treatment, having regard to perceived risks and advantages;
- ensures that patients are given information actually requested; and
- enables doctors to know what standard is to be met in general, even for particular conditions and for particular patients.

The circumstances in which doctors should consciously withhold information should be limited in range. There should be only a limited class of circumstances clearly capable of justification, for example, emergency treatment.

The consequences of failure to meet the established standard should include general liability in negligence and disciplinary action.

FOOTNOTES

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1. Dr John Vallentine said that failures of communication form the basis of 30% of all medical negligence claims in Australia. (The Medical Defence Union, Sydney, opens 1,000 new litigation files each year.) *Australian Doctor Weekly*, 17 June 1988.
2. And see ALRC 47: *Third Community Law Reform Report. Enduring Powers of Attorney* (1988).

2. Problems In Communication Between Doctors and Patients

Concerns of some patients

10. Although many patients are quite satisfied with their relationship with their doctors, some think that they are not always allowed to participate sufficiently in deciding about their treatment or given enough information to enable them to do so. These concerns are evident in the findings of the Victorian Commission's studies of patients' experiences and attitudes.¹ The findings of those studies accord with those of extensive surveys conducted for the United States President's Commission in 1982² and with the views put by patient groups in meetings with the Victorian and New South Wales Law Reform Commissions.

11. Other inquiries in Australia have also found evidence of communication problems between doctors and patients:

The *Social Development Committee* of the Victorian Parliament, investigating the need for a health complaints service in 1984, conducted 823 interviews during a 3-day Health Services Complaints Phone-in. Thirteen percent of the callers complained about poor communication and 27% about the poor attitude or behaviour of health care providers. Thirty five percent of the total complaints were against institutions such as hospitals and 30% against individual doctors.³

The Victorian Health *Complaints Advisory Link Line* (Health CALL), was established as a pilot project to monitor health complaints following the Social Development Committee's Report. In 1986/87 it recorded 495 complaints about aspects of communication out of a total of 2,617 complaints in that year. One hundred and eighty complaints about communication related to doctors and 162 to hospitals. In 1987/88 there were 697 complaints about communication in a total of 2,813; 294 related to doctors and 155 to hospitals.⁴

The *Office of Health Services Commissioner* in Victoria was established following the Social Development Committee's Report. In its first year of operation from March 1988 to March 1989) 142 complaints about communication were reported in a total of 1,172 statutory complaints. The Commissioner is of the opinion that some failure of communication or expectation is the basis for at least 80% of the 2,500 inquiries from which the statutory complaints are derived. Many of these initial inquiries were resolved when people were given an explanation in terms they could understand.⁵

The *Health Complaints Unit* of the *New South Wales Department of Health* reported 1,927 complaints in 1987, of which 64 specifically concerned failure to communicate or misleading information. In 1988, under new coding, 83 complaints about communication were reported in a total of 1,084 complaints. The Director of the Health Complaints Unit reported that a very large proportion of complaints were resolved when more information was given to complainants, suggesting that a lack of communication was a factor in many more complaints than the figures show.⁶ This also demonstrates the role that fuller information between doctors and patients can have in preventing disputes arising.

The *Women's Health Policy Working Party*, Victoria, reported in 1987 that the most frequent single concern it heard was that doctors did not communicate adequately with women patients. One of the Working Party's major findings was that doctors often failed to provide adequate information about health issues.⁷

The Commonwealth *Medical Education Inquiry* in 1988 reported that submissions received from consumer and community groups 'shared basic concerns regarding competencies seen as central to medical practice, such as communication skills, counselling skills ... [the] ability to recognise patients as people with the right to make decisions about their own care, and sensitivity to the diversity of the views and interests of patients'.⁸

The *Royal Women Is Hospital Study* in 1988 reported that 69% of the patients studied said that they were not given enough information about their treatment or care and 77% said that they wanted more information. Particular concerns were for more information before consenting to treatment and before being examined by students.⁹

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12. Many submissions¹⁰ received from patients, patient organisations and the general community said that lack of information and lack of patient involvement were widespread problems. For example:

Several District Health Councils in Victoria met patients specifically to discuss doctor/patient communication. They heard many accounts of communication problems.¹¹

Several nurses wrote, both generally and specifically, of their experiences and observations. They said that patients are often not given information, or 'quality' information, or 'comprehended' information.¹² This created problems, not only for patients but also for other health carers, such as nurses or aides, who were then uncertain of their role and legal position.

Some patients described cases in which they may have been given insufficient information. For example, a patient was prescribed Timoptol eye drops for glaucoma. She said that she became depressed when she used the medication. The depression was relieved when the patient complained to the doctor who then changed the medication saying it was a known possible side-effect. She said: 'To me it is immoral and should be illegal for a patient to be prescribed a medication that has been known in some cases to cause depression, unless given the full facts. Especially when there is other treatment available. Informed consent should be a patient's right'.¹³

A number of patient support groups and organisations which act as an information resource for patients said that their experiences indicated that many patients who had chronic illnesses were often not given enough information. This problem was exacerbated by the patients' developing understanding of their condition and their need for more specific information about procedures and alternatives.¹⁴

Doctors' views

13. Doctors' views were widely canvassed during the consultation process. A series of meetings was held by the Victorian and New South Wales Commissions with representatives of professional bodies and specialist colleges (Appendix 3). Also, many submissions were received from general practitioners, specialists and medical organisations (Appendix 4). Some doctors have apparently not yet accepted that patients should be given enough information to decide for themselves what treatment they will undertake. These doctors believe that they should choose the most appropriate treatment for the patient and then simply present the patient with the choice whether to have it.

14. Most doctors acknowledge the importance of giving patients information so they can make informed decisions. However, many of them are concerned about the practical difficulties associated with providing the relevant information to patients with widely differing characteristics in a variety of different situations. In some cases -for example, in an emergency - it is simply not possible to give the relevant information. In some cases, there may be a risk that providing the information would harm the patient's health or welfare. Some patients may simply not want to be told about the potential risks of treatment, preferring to leave the decision entirely to the doctor. There are considerable variations in the practices of different doctors in giving information, even in similar cases. They place different emphases on factors that might influence how much information they should give in a particular case, such as whether the information might dissuade the patient from undertaking the recommended treatment, or whether the information might itself worsen the patient's medical condition. The variations in doctors' practices and the concerns felt by some doctors were revealed by:

consultations with and submissions received from doctors and medical organisations;¹⁵

a survey of doctors conducted by the Victorian Commission;¹⁶ and

direct observations of clinical consultations by a research officer of the Victorian Commission.¹⁷

15. The points made by doctors and medical organisations included the following:

communication is a vital part of medical practice;

there are areas in which communication could be improved;

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the task of trying to improve communication is most important;

there is a growing demand from patients for better and fuller information; and

the inquiries and consultations leading to this report have already had a significant impact in promoting discussion and in changing medical practice.

16. A few medical submissions provided examples of cases in which sufficient information had not been given. One specialist said that he had encountered many patients who had undergone operations and procedures 'without any effort having been made to apprise them of what was entailed'.¹⁸ Another specialist said that information-giving is a significant and widespread problem, particularly in public hospitals where it is often delegated to junior medical staff.¹⁹ The Doctors' Reform Society also said that cases came to members' notice where patients had not been adequately informed and this aspect of doctors' service needed to improve.²⁰

17. Many of the medical submissions, however, expressed the view that the current law and practice is quite satisfactory and that patients are generally satisfied with the information they are given.²¹ They emphasised the need for doctors to retain a discretion in relation to information-giving and questioned whether it is possible, or even desirable, to state general requirements.²²

FOOTNOTES

1. Law Reform Commission of Victoria, *Informed Decisions about Medical Procedures: Doctor and Patient Studies*, 1989.

2. President's Commission for the Study of Ethical Problems, *Making Health Care Decisions, Vol 2: Empirical Studies of Informed Consent*, USGPO, 1982.

3. Social Development Committee, *Final Report upon Complaints Procedures against Health Services*, VGPO, 1984.

4. Health Complaints Advisory Link Line Annual Reports, 1986-87, 1987/88.

5. Communication from the Commissioner for Health Services.

6. New South Wales Law Reform Commission consultation with the Health Complaints Unit. The 1987 Annual Report notes an escalation of patient complaints centring on:

perceived inadequate communication skills on the part of the medical practitioner;

the failure of the medical practitioner to disclose information to patients;

the failure of the medical practitioner to allow patients to participate in the decision making process about their treatment;

the failure of the medical practitioner to obtain proper consent for treatment from patients.

7. The Women's Health Policy Working Party, *Why Women's Health*, VGPO, 1987.

8. Committee of Inquiry into Medical Education and the Medical Workforce, *Australian Medical Education and Workforce into the 21st Century*, AGPS, 1988, 50.

9. Royal Women's Hospital, *Our Health, Our Hospital: Victorian Women talk with Our Hospital*, 1988.

10. Submissions from patients, patient organisations and the general community are listed in Appendix 4.

11. Submissions: Keysborough Women's Group, Dandenong and Springvale District Health Councils, Southport Community Health Centre.

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12. Submissions: Ms M J Johnstone; Ms T Mercovich; Ms P Pickert.

13. Submission: Mrs Sheppee.

14. Cancer Support Groups (Frankston & Ballarat); Endometriosis Association; Women in Industry Contraception and Health; Council of Self-Help Groups; Australian Huntington's Disease Association (NSW); Women's Health Information Resource Collective; Australian Consumers' Association (NSW), Consumers' Health Forum of Australia (ACT), Health Issues Centre (Vic), Chronic Pain Association, Arthritic Women's Task Force (Vic), Maternity Alliance (NSW), Back Pain Association (Vic), Handicapped Citizens' Association (ACT), AIDS Council of NSW.

15. These consultations and submissions are listed in Appendices 3 and 4.

16. Law Reform Commission of Victoria, *Informed Decisions about Medical Procedures: Doctor and Patient Studies*: 1989.

17. Consultative sessions of three general practitioners and three specialists seeing 46 patients were observed. See Law Reform Commission of Victoria, *Informed Decisions about Medical Procedures: Doctor and Patient Studies*, 1989.

18. Submission: Dr T Sandeman, Radiation Oncologist, Melbourne.

19. Submission: Squadron Leader Patten, RAAF Base, Laverton, Victoria.

20. Victorian Law Reform Commission consultation.

21. Submissions: Australian Society of Anaesthetists; Australian Association of Surgeons, Victorian Committee; Medical Advisory Committee, Royal Southern Memorial Hospital; Medical Advisory Committee, Amalgamated Melbourne and Essendon Hospitals; Dr M Jelinek, Cardiac Physician.

22. Submissions: Dr P Nisselle, General Practitioner; Mr Peter Field, Surgeon; Dr W Jame, General Practitioner; Dr J Bolton, Physician.

3. The Law

18. A failure to supply information to a patient about a proposed treatment or operation may in some cases expose a doctor to legal liability. Two main areas of the law require consideration: trespass to the person and negligence. Each is concerned with providing remedies for wrongful conduct. The question is whether a doctor's failure to inform is such that a patient should be entitled to claim compensation because of it. The law is therefore concerned with defining a minimum acceptable level of practice. This should be kept in mind when assessing the adequacy of the law.

Failure to obtain consent: trespass

19. It is sometimes suggested that the law requires that a patient's *informed consent* must be obtained before any medical treatment is carried out. This is not strictly correct. The position is that any invasive medical procedure performed without consent constitutes a trespass to the person for which damages may be claimed, unless the failure to obtain consent is justified by necessity (for example, in an emergency).¹ In this context 'consent' means consent to the general nature and quality of the proposed procedure. The role of the law of trespass in the area of *informed consent*, as that term has come to be understood, is limited. Consent to a procedure will not be ineffective merely because it was obtained without disclosure of associated risks and possible alternative treatments. The courts have now accepted that the proper sanction for failure to disclose this sort of information lies in the tort of negligence.

Failure to inform: negligence

20. Failure by a doctor to disclose the risks associated with a proposed treatment and possible alternative treatments may expose the doctor to liability for damages in negligence if something goes wrong. For an action against the doctor to succeed, two things must be established:

that the doctor's failure to disclose the information was unreasonable; and

that this failure was a cause of harm to the patient.

The scope of the duty of doctors to disclose information is examined below. To satisfy the second element (causation), the patient must establish that he or she would not have consented to the treatment had proper disclosure been made and that injury was suffered due to the treatment. The mere fact of treatment without informed consent will not be regarded as compensatable injury. The causation element of the cause of action will often be extremely difficult to establish in practice even when it is clear that the treatment went badly wrong and the doctor failed to warn of the risk. This is because the patient usually cannot establish that he or she would have decided against the treatment if full disclosure of the risk had been made. For this reason it has been suggested by some that patients should be compensated for medical injuries even if they are not able to prove the doctor was negligent.²

21. In the jurisdictions covered in this report, there are different rules and practices as to whether a doctor's liability for damages for alleged negligence will be determined by a judge or a jury. In Victoria³ and New South Wales⁴ a jury will normally be used if either party wishes it. Juries are in fact used in a significant proportion of cases of medical negligence. On the other hand, there has never been a civil jury trial in the Australian Capital Territory, even though provision exists for it.⁵

22. The duty of doctors to disclose information to patients about proposed treatments can be stated quite simply. The test is whether the doctor has behaved reasonably in all the circumstances of the case. The question of reasonableness stands to be determined by the judge or jury in each case. Because the practice of medicine involves special skill, the doctor's conduct is not judged by reference to the standard of 'the ordinary person'. Rather, the doctor's conduct is judged according to the standard of expertise to be expected of a medical practitioner of the class to which the defendant belongs. Greater skill might be required of a specialist than a general practitioner.

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23. In areas of technical knowledge and expertise, it is necessary for expert evidence to be called so the judge or jury can understand and assess the case before them. Evidence of the common practice within a profession or industry will usually be called in order to determine whether the defendant's conduct departed from normal standards. One area in which the law in medical negligence cases has undergone change is in determining the effect that is to be given to evidence of standard medical practice.

24. A principle was stated by Mr Justice McNair in *Bolam v Friern Hospital Management Committee*:

A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that particular art ... Putting it the other way round, 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.⁶

25. *Bolam* lays down a test ('the *Bolam* test') by which the question of negligence is determined solely by reference to whether the conduct in issue conformed to an accepted body of medical practice, not necessarily the most commonly accepted practice. If it did conform to an accepted body of practice, the doctor cannot be held to have been negligent. Such a test would preclude a finding that a common practice is negligent, even if it quite plainly is. This is clearly unsatisfactory and would place the question of negligence in medical practice beyond the supervision of the courts. If applied to the standard of disclosure, the *Bolam* test would allow the paternalistic attitudes of some members of the medical profession to continue without sanction despite growing community sentiment in favour of fuller communication between doctor and patient. Mr Justice Reynolds rejected this approach in *Albrighton v Royal Prince Alfred Hospital*:

It is not the law that, if all or most of the medical practitioners in Sydney habitually fail to take an available precaution to avoid foreseeable risk of injury to their patients, then none can be found guilty of negligence.⁷

This approach has been followed in later South Australian cases, including the Full Court decision discussed below.⁸

26. The Commissions have given serious consideration to the need for statutory abrogation of the *Bolam* test. Abrogation is not recommended. The better view is that the *Bolam* test would not be applied by Australian courts. The proper role for evidence of professional practice was described by Mr Justice King, Chief Justice of the Supreme Court of South Australia in 1982 in *F v R*:

In many cases an approved professional practice as to disclosure will be decisive. But professions may adopt unreasonable practices. Practices may develop in professions, particularly as to disclosure, not because they serve the interests of the clients, but because they protect the interests or convenience of members of the profession. The court has an obligation to scrutinize professional practices to ensure that they accord with the standard of reasonableness imposed by the law. A practice as to disclosure approved and adopted by a profession or section of it may be in many cases the determining consideration as to what is reasonable. On the facts of a particular case the answer to the question whether the defendant's conduct conformed to approved professional practice may decide the issue of negligence, and the test has been posed in such terms in a number of cases. 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.⁹

Determining reasonable disclosure

27. The extent of the information that doctors should give patients will depend on what is reasonable in the circumstances of each case. Although the general principles can be stated, it may not always be easy to determine exactly how the principles are to be applied in a particular case. Patients' involvement in decision-making and the provision of information to patients have been considered in only a small number of Australian cases,¹⁰ mostly in South Australia.

28. The courts have provided some guidance in setting out some of the matters that a doctor should consider in deciding what information should be given. They include:

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the personality and temperament of the patient and the patient's attitude;¹¹

the patient's level of understanding. Doctors need not crossexamine patients exhaustively to ensure they understand and will remember the doctor's advice but they should give information they think the patient will understand after 'a fair appraisal of [the] patient's intelligence and temperament and apparent understanding, made in the light of the simplicity or complexity of the recommendation [the doctor] is making';¹²

the nature of the treatment. More drastic treatment (such as major surgery) may require more information;¹³

the magnitude and likelihood of the possible harm. Information about the possibility of serious harm should normally be given even if the chance of it occurring is slight.¹⁴ Similarly, information should generally be given if the potential harm is relatively slight but the risk of it occurring is great.

29. These matters should be weighed in a manner consistent with the overall purpose of disclosure:

to provide the patient with the information necessary to enable him to make informed decisions concerning his future and, in particular, whether to undergo proposed treatment.¹⁵

However, this is qualified by the overriding criterion of reasonableness. In cases of emergency it may not be reasonable to expect a doctor to give all, or possibly any, of the information that would normally be given. This is because it is assumed that the patient would have consented to necessary treatment. The courts have not defined what constitutes an emergency; in particular whether it must be threatening to the patient's life or whether it is sufficient that there is a risk of grave physical or mental injury to the patient.¹⁶ In practice, doctors often face difficult decisions in situations which may not be life-threatening. In judging the doctor's conduct in such circumstances, the principal question is whether the doctor's actions accorded with what a reasonable doctor would have done in similar circumstances.

30. Again, there may be cases in which reasonable care justifies or requires withholding information from the patient. A doctor might justifiably refrain from giving information that would normally be given to a patient considering a particular treatment if he or she 'judges on reasonable grounds that the patient's health, physical or mental, might be seriously harmed by the information'¹⁷ or when the doctor 'reasonably judges that [the] patient's temperament or emotional state is such that [the patient] would be unable to make the information a basis for a rational decision.'¹⁸ Even if a patient directly requests information, a doctor's duty to act in the patient's best interests 'may justify or even require an evasive or less than fully candid answer'.¹⁹ This is especially so if the question arises from a desire for reassurance rather than information. This is sometimes called *therapeutic privilege*.

31. The extent to which a doctor may justifiably withhold information which the doctor believes might harm the patient's welfare is, however, strictly limited. A doctor should not lightly decide that a patient should not be fully informed.'The governing consideration is the right of every human being to make the decisions which affect his own life and welfare and to determine the risks he is willing to undertake'.²⁰

32. The extent of disclosure required will also be governed in part by the patient's expressed desire for information. If a patient specifically inquires about risks or requests other information, those questions should generally be answered.²¹ Conversely, the patient might exercise his or her autonomy by requesting not to be given information and by accepting the decision of the doctor.²² However, there may be difficulties for the doctor in deciding what minimum information should be given to a patient who wants 'to leave it to you, doctor'. For example, if there is a choice for the patient between a lumpectomy and a mastectomy, how much information should the doctor give about the two operations? The doctor has to be sure that the patient is sufficiently informed to be able to decide to leave it to the doctor and that the patient is aware that he or she has the right to decide. This may depend partly on how well the doctor knows the patient. Is the patient refusing the information because he or she understands broadly what is proposed and does not want to know all the details, or is it rather that the patient is frightened or confused, and does not want, or feel able, even to consider what the procedure involves? If the latter is the case, the doctor should take care to ensure that the patient understands broadly what is involved.

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Consent forms

33. If the patient signed a consent form stating that he or she consents to the procedure in question, that may be substantial evidence that the patient consented but it is not conclusive. Similarly, if the patient signed a consent form acknowledging that the nature, implications and risks of the proposed procedure have been explained, that may be substantial evidence that information was given, but again it is not conclusive on the question whether the information was given or was adequate.

Administrative complaints procedures

34. In both Victoria and New South Wales patients may complain about health services whether or not they have suffered an injury. In Victoria, section 16(1)(b) of the *Health Services (Conciliation and Review) Act 1987* enables a person who uses or receives health services to complain to the Health Services Commissioner if a health service provider 'has acted unreasonably in the manner of providing a health service for the user'. This has been interpreted as including the provision of adequate information and allowing the patient to participate in making health care decisions (both referred to in the preamble to the Act). The Health Services Commissioner will provide practical assistance to help the user resolve the matter with the provider. If the matter is not resolved the Commissioner will consult the relevant registration board (which is the Medical Board in the case of medical practitioners) and then decide if the complaint is suitable for conciliation, or failing that, formal investigation. Alternatively, a person may complain directly to the Medical Board. Its powers to investigate and discipline doctors are contained in the *Medical Practitioners Act 1970*. The Board can impose a range of penalties and has the ultimate sanction of deregistration.

35. In New South Wales, complaints about professional misconduct can be made to the Department of Health or the New South Wales Medical Board. There are various avenues for hearing complaints. Serious matters that might lead to the suspension or deregistration of a doctor are referred for a formal hearing by the Medical Tribunal. Less serious matters are referred to a Professional Standards Committee, which might simply reprimand the doctor or require the doctor to attend counselling or education courses. The Complaints Unit of the Department of Health also has a role in counselling and promoting conciliation of complaints. The flexibility of these procedures and the range of responses available make them suitable for dealing with complaints concerning failure to provide information to patients. This means that complaints can be heard, and counselling given to doctors or other action taken, before someone is injured.

36. In the Australian Capital Territory, the procedure is similar to that in New South Wales but less comprehensive. All complaints against individual doctors are referred to the Chairman of the Medical Board. Those that are considered not to be vexatious are first referred to the doctor concerned for his or her comments and then to the Board for further consideration. If the Board considers that the complaint involves negligence, the complainant is informed that the matter cannot be considered further by the Board but must be pursued in the courts. Complaints other than those involving negligence are dealt with by the Board either by a process of informal conciliation for less serious matters or by setting up a formal inquiry for matters involving professional misconduct. Proved professional misconduct may result in a reprimand, suspension or deregistration. There is no legislative guide as to what amounts to professional misconduct (except in relation to advertising). The Board's issued notes define 'professional misconduct' as 'conduct which would reasonably be regarded as disgraceful or dishonourable by his professional brethren of good repute; or serious misconduct judged according to the rules, written or unwritten, governing the profession'. The Board takes cognisance of and is largely guided by the Code of Ethics of the Australian Medical Association. It is uncertain whether a failure properly to inform a patient would be regarded as professional misconduct, having regard to the way the Australian Capital Territory legislation is applied in practice.

FOOTNOTES

1 . Some groups suggest that HIV testing without consent may be justified in the interests of health care workers or of public health. This is controversial and is not supported by the interim guidelines of the Australian Health Ministers' Conference (March 1989) nor the National HIV/Aids Strategy Paper (August 1989).

2. This was discussed at the 1989 Australian Health Ministers' Conference.

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3. See, General Rules of Procedure in Civil Proceedings 1986 (Vic), Order 47.02; *County Court Act 1958* (Vic) s67.
4. *Supreme Court Act 1970* (NSW) ss86, 89(1); *District Court Act 1973* (NSW) ss78, 79A.
5. *Australian Capital Territory Supreme Court Act 1933* (Cth) s14.
6. [1957] 2 All ER 118.
7. (1980) 2 NSWLR, 542, 562-3.
8. Although the House of Lords recently said that the *Bolam* test is appropriate to decide whether a proposed operation is in a patient's best interests: *F v West Berkshire Health Authority* [1989] 2 All ER 545.
9. (1983) 33 SASR 189, 194.
10. For example, *F v R*, n 7; *Gover v State of South Australia and Perriam* (1985) 39 SASR 543; *Battersby v Tottman and State of South Australia* (1985) 37 SASR 524; *D v S* (1981) 93 LS (SA) JS 405. These cases are described in the Victorian Law Reform Commission's Discussion Paper No 7, *Informed Consent to Medical Treatment*, 1987, 12-16.
11. *F v R*, n 7, 206 (Bollen J).
12. *Gover v South Australia and Perriam*, n 8, 558 (Cox J).
13. *F v R*, n 7, 192 (King CJ).
14. *Battersby v Tottman and State of South Australia*, n 8, 542 (Jacobs J). Comments about the risk of death or total paralysis in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital and Others* [1985] 1 AC 871 and the Canadian cases: *Reibl v Hughes* (1980) 114 DLR (3d) 1; *Haughian v Payne* [1987] 40 CCLT 13.
15. *F v R*, n 7, 192 (King CJ).
16. The South Australian *Consent to Medical and Dental Procedures Act 1985* enables emergency medical procedures to be carried out on persons unable to consent if the doctor 'is of the opinion that the procedure is necessary to meet imminent risk to the person's life or health' (s7(2)(b)(i)). 'Health' is not further defined. Today the general consensus would include all aspects — physical and mental.
17. *F v R*, n 7, 193, King CJ. However, if there is only likely to be a slight risk to the patient, but the risk of an adverse reaction on the part of the patient is very high, then a doctor would not be considered negligent if he or she withheld information.
18. *F v R*, n 7, 193 (King CJ); *Battersby v Tottman and State of South Australia*, n 8, 527 (King CJ).
19. *F v R*, n 7, 192 (King CJ).
20. *F v R*, n 7, 192-3 (King CJ).
21. *F v R*, n 7, 192 (King CJ).
22. *F v R*, n 7, 193 (King CJ): '[A] doctor is not required to inflict on his patients information which they do not seek and do not want. Many people are prepared to place themselves in the hands of their doctors and to leave all decisions to them'.

4. Recommendations

37. The common law already emphasises the importance of informed decision-making by patients. It does not provide, however, specific and detailed guidance to doctors and patients on the nature and amount of information that should be given in particular cases. For this reason, other means should be considered to deal with the communication problems described earlier. Legislative and non-legislative measures are now considered.

Legislation

38. In some jurisdictions, legislation has been enacted stating the type of information that doctors are required to give to patients. In South Australia, for example, there is legislation¹ in general terms on the provision of information to patients. In Victoria and New South Wales there is legislation² on the provision of information to mentally-ill patients undertaking certain medical procedures.

39. Legislation can take three forms:

a statute;

subordinate legislation, made by a person such as the Minister for Health (Federal or State), or a body such as the National Health and Medical Research Council; or

guidelines under a statute or under regulations, prepared by a similar person or body.

40. Legislation requiring doctors to give certain information to patients may be thought to have the advantage of providing a clear and precise statement of the requirements concerning information-giving and the consequences of failing to meet those requirements. There are, however, several reasons for not attempting comprehensive legislation.

41. First, the common law already provides a satisfactory general standard and legislation is not necessary for this purpose, other than to extend the consequences of non-compliance with the common law requirements (see below).

42. Secondly, while more specific and practical guidance to doctors on the provision of information might be desirable, legislation is not a suitable vehicle for providing it. A legislative model, particularly one providing for sanctions for non-compliance, would have to retain sufficient flexibility to deal fairly with all cases that might arise. The South Australian, Victorian and New South Wales legislation mentioned above, like the common law on which it is based, gives only general guidance on the nature and amount of information that should be given to patients. For example, the South Australian Act requires 'proper and sufficient explanation of the nature and likely consequences of the procedure' but that leaves open to interpretation what 'proper and sufficient explanation' is. As the Working Party whose report led to the South Australian legislation acknowledged, the formulation offers little practical guidance to doctors on the precise content of the information to be given. The Working Party suggested that the legislation should be supplemented by guidelines detailing this information.³ The Victorian provisions on psychosurgery and electro-convulsive therapy offer little more guidance. They require 'a clear explanation containing sufficient information to enable him or her to make a balanced judgment; and ... an adequate description of benefits, discomforts and risks without exaggeration or concealment; and ... [advice] of any beneficial treatments; and ... [that] any questions relating to the techniques or procedures to be used asked by the person have been answered and the answers have been understood by that person . . .'.⁴

43. Thirdly, legislation is rigid. Amendment to statutory standards may be required due to advances in medical knowledge and changes in practice. It is sometimes a complex matter to amend legislation, and it always takes some time. It is dependent on the Government's priorities, and on the legislative and parliamentary timetable. Although regulations and legislative guidelines are much more easily and speedily amended, they too may be relatively rigid and difficult to amend.

Recommendation 1

The common law standard of reasonable care which now applies to the provision of information to patients concerning a proposed treatment or medical procedure should not be replaced by a statutory standard.

Non-legislative guidelines

44. Non-legislative guidelines, stating doctors' obligations in general and in particular cases, would be a more effective means of improving communication between doctors and patients. If doctors are involved in drafting the guidelines, they are likely to enjoy a high level of support within the medical profession. There is already recognition of the value of guidelines within the medical profession. Guidelines are more flexible than legislation and need not be limited to a statement of general principles. They may include examples to assist understanding and to explain general statements. They can also be altered relatively easily in the light of changing circumstances. Guidelines can be given recognition in the legal process (see below, para 53 in relation to court proceedings and para 55 in relation to disciplinary proceedings). The Royal Australian College of Physicians has already taken steps in this direction by publishing *Guidelines for the Medical Profession on Informed Consent*.⁵

Possible objections to guidelines and response

45. The Commissions acknowledge that some doctors may oppose the preparation of guidelines outlining the information that they should give patients. Possible grounds of objection are considered below:

doctor-patient relationships are so varied that it is not useful to state general rules concerning the information to be given to patients. While difficulties may arise in preparing the suggested guidelines, they can be overcome. First, the guidelines could be made more specific and useful if examples were given to explain how they would operate in practice. Second, if the guidelines did no more than focus attention on the importance of giving patients an opportunity to decide for themselves about their treatment and giving them sufficient information to make that decision, they will serve a useful purpose. And third, if doctors are involved in preparing the guidelines, doctors can be expected to be sympathetic to the problems arising in everyday medical practice and to take them into account in the guidelines.

it will not be possible to make adequate provision in general guidelines for doctors to exercise their discretion to withhold information that they believe might seriously harm a patient's health or welfare. This matter would require careful drafting and a range of examples would, it is suggested, need to accompany the guidelines. It is essential that a doctor's discretion should be retained in some cases, for example, where he or she believes on reasonable grounds that the patient's health would be seriously harmed by the information. On the other hand, if the discretion is too broad, it may overwhelm the requirement that patients should generally be given sufficient information to make their own decisions. The discretion to withhold information should not be exercised lightly. A balance could be achieved by a provision that doctors may withhold information that would otherwise be required to be given only if they believe *on reasonable grounds* that the patient's health or welfare might be seriously harmed by that information being given.

if the guidelines require that additional information should be given to patients, that will unduly increase the cost of medical consultations. There is no evidence to support a conclusion that the overall cost of medical treatment would be increased by giving adequate information to patients.⁶ It may even be decreased by improvements in the efficiency of treatment following better communication between doctor and patient. Inadequate information about prospective treatment may also have a social cost, in the form of stress and anxiety for the patient and damage to the doctor-patient relationship.

Guidelines

46. The Commissions do not have either the medical expertise or the consumer input to draw general guidelines or the more detailed ones that will be required for particular specialties. The National Health and Medical Research Council (NHMRC) would be a more appropriate body because:

it has the necessary expertise and experience in drawing guidelines in relation to medical matters;

it has the respect and trust of doctors;

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it is a federal body and its guidelines will apply throughout Australia. This is an ideal method of ensuring there is one code of practice throughout the country;

it reports annually to the Commonwealth Minister for Health and has direct links with State Ministers for Health.

47. Discussions have been held between representatives of the Australian, New South Wales and Victorian Commissions and Dr Diana Horvath, Chairman of the Health Care Committee of the National Health and Medical Research Council. Dr Horvath also discussed the matter with Professor John Chalmers, Chairman of the National Health and Medical Research Council. As a result of these discussions, the National Health and Medical Research Council will establish a sub-committee to prepare guidelines concerning the information that doctors should give patients in relation to particular medical procedures. The Commissions will be invited to be represented on the sub-committee which, in accordance with the Health Care Committee's normal practice, will include wide representation from the general community as well as the medical profession.

Content of guidelines

48. Guidelines on the provision of information to patients could emphasise not only that doctors should give information to patients but that doctors should focus on patients' needs in deciding what information should be given. The guidelines could state general requirements for information-giving and be extensively illustrated by reference to specific procedures. For example, the first guideline could state that doctors should generally give patients sufficient information to enable them to make an informed decision about what diagnostic tests or treatment they will undertake. This guideline could be followed by a 'checklist' of matters on which information should be given, including, for example, diagnosis, prognosis related to options for treatment, and possible risks and complications. Examples could be given of information that would be appropriate in particular cases. For instance, the guidelines dealing with a particular condition might set out the options for treatment of that condition, together with their likelihood of success and associated risks, and direct the doctor to discuss these matters and the general nature of each treatment with the patient.

49. The guidelines could recognise that, in exceptional cases, doctors may be justified in giving less information than would usually be required. The guidelines could make it clear that this is only allowable where the doctor is clearly satisfied on reasonable grounds and after reasonably careful investigation that the patient understands the general nature of the proposed procedure and agrees to undertake it but:

the patient does not want any further information about the potential success, risks, complications or side-effects of the proposed procedure or any alternative procedure; or

the patient's health or welfare might be seriously harmed if he or she were informed of those matters; or

an emergency exists in which it is not possible to give the information.

The guidelines could also require that doctors give more information if it is specifically requested by a patient.

50. In order to have an impact on professional practice and public attitudes, it is important that the guidelines be disseminated widely. The ways in which this might be achieved include the following:

by professional education programs in medical undergraduate courses and post-graduate courses, and continuing education such as that already being developed by some faculties.⁷ Matters to be considered could include communication skills - listening, feedback techniques and the use of non-technical language; the nature of negotiation, decision-making, and behavioural processes, and an understanding of the needs of minority groups. Some instructors in these courses could come from outside the medical profession. If and when attitudinal change occurs, it may be that communication skills could be one of the criteria for the selection of clinical teachers.⁸

by health caregivers looking at standards for giving information in quality assurance and peer review programs. However, unless used carefully, these techniques may be criticised for maintaining the status quo.⁹

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by major teaching and private hospitals developing protocols for giving information to patients. The development of administrative procedures (which many hospitals have already undertaken) to ensure that adequate information is given could be a requirement of accreditation of hospitals. Hospitals could also assist patients by providing them with written information and by supporting the preparation of such material within departments.^{10,11}

by health complaints and medical disciplinary bodies reporting regularly on doctor/patient communication issues raised before them and their decisions on those issues.

by continuing emphasis in clinical education on the importance of using an accredited interpreter whenever there are language difficulties.

by patient education. Research indicates that many patients have little knowledge of health, health services and medical procedures. Both education and easier access to information through appropriate community groups and medical institutions would apprise patients of the role they could take in obtaining information and participating in decision-making.¹² Patients need information about health in general and their specific illness to enable them to select an appropriate service for their needs,¹³ to take responsibility for their health, and to help them make decisions.¹⁴ Patients can be helped to understand the procedural steps of a medical interview, to think precisely about their symptoms and the degree of discomfort, and to be able to list them. They could also learn to give relevant information about their circumstances, write reminders for themselves about questions they need to ask, and learn to indicate whether they have understood. It is recognised that education of patients will only assist, not solve, all the problems of information exchange in the medical interview. But an 'educated' patient would act as a catalyst for change.

by self-help groups such as the Australian Cancer Patients Foundation, the Australian Huntington's Disease Association and the Victorian Back Pain and Chronic Back Pain Associations. Patient education is also being undertaken by Community Health Centres and some hospitals. This should be encouraged.

by other health caregivers providing information. This already occurs in practice¹⁵ and greater use could be made of it, provided that doctors retain the ultimate responsibility for ensuring their patients are informed about particular procedures. Other health care professionals are concerned about their role and responsibilities in giving information.¹⁶

Recommendation 2

Guidelines for the provision of information to patients concerning a proposed treatment or procedure should be formulated by the National Health and Medical Research Council.

(a) In considering the guidelines, the Council should take account of the following matters:

(i) the need in each case for doctors to pay attention to the patient's circumstances;

(ii) the fact that less information may be necessary if the doctor is clearly satisfied on reasonable grounds, and after reasonably careful investigation, that the patient understands and agrees to the proposed procedure, but does not want more information; or that the patient's health or welfare might be seriously harmed if the patient were more fully informed about the procedure; or that an emergency exists in which it is not possible to give the information;

(b) the appropriate authorities should consider including discussion of the guidelines in medical courses as a means of educating medical students in relation to giving patients appropriate information. The guidelines might also be referred to in quality assurance and peer review programs, hospital protocols and hospital accreditation reviews. Patient education and self-help programs might also inform patients about the guidelines to help patients communicate with their doctors.

Evidentiary status of the guidelines

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51. The Commissions recommend that legislation should be enacted giving the proposed guidelines a specified status in relation to the law of negligence. This could be done in two ways. First, the guidelines could be made *conclusive evidence* of the standard of reasonable care in relation to the provision of information about proposed treatment, or of what constitutes 'approved professional practice' as that term was used by Chief Justice King in *F v R* (see para 26). And secondly, the guidelines could be made *admissible evidence* of the standard of reasonable care or approved professional conduct, leaving it open to the courts to admit other evidence as well on the topic.

52. There are several problems with the first approach. Those who formulate the guidelines would be required to prepare guidelines of universal application. It would be extremely difficult to draft guidelines that were sufficiently precise to define a standard for legal purposes yet which would operate fairly in all cases. There may be, for example, circumstances in which a doctor might contravene a relevant guideline yet be found to have acted reasonably, particularly if there is evidence that many doctors disagreed with or disregarded the guideline. Conversely, in the circumstances of a particular case, the failure to provide certain information to a patient might be unreasonable notwithstanding that the relevant guideline did not require that such information be generally given. A conclusive evidence model would not have the flexibility to take account of such cases. Moreover, it would hand over to a non-judicial and largely professional body the task of deciding the standard of disclosure required of doctors. The Commissions believe that the Courts should continue to perform their traditional role, common to all areas of negligence law, as the final arbiter of reasonable conduct.

53. The Commissions therefore recommend the second option: that legislation should be enacted requiring that, in an action for damages for professional negligence, the guidelines are admissible evidence and that the courts will consider them in deciding whether a doctor has acted reasonably in relation to the provision of information. Evidence could, however, also be adduced that compliance with the relevant guidelines in a particular case was impracticable, or that many doctors did not follow the guideline or would not have done so in the particular circumstances. It is expected, however, that the courts would give considerable weight to the guidelines and that, as a practical matter, it would be for a doctor to show why it was reasonable not to have observed them in a particular case.

Recommendation 3

Legislation should be enacted requiring that, in an action for damages for professional negligence, the courts will consider the guidelines in deciding whether a doctor has acted reasonably in relation to the provision of information.

Disciplinary proceedings against doctors

54. Failure to provide adequate information of sufficient degree to attract the disapproval of the doctor's peers would probably already constitute 'professional misconduct' under the *Medical Practitioners Act 1970 (Vic)*, the *Medical Practitioners Act 1938 (NSW)*¹⁷ and the *Medical Practitioners Registration Act 1930 (ACT)* as they now stand. However, the obligation of doctors in this regard should be emphasised. This should be done by an amendment to the legislation to make it clear that professional misconduct includes failure to give adequate information and that, in deciding whether adequate information has been given a court, board or tribunal should take into account any applicable standard or guideline published by the NHMRC.

55. What amounts to a failure to provide 'adequate information' would be a matter for the disciplinary tribunals and would be determined in accordance with the standards of the profession. As with a negligence claim, failure to give information as required by the guidelines would, as a practical matter, place an onus on the doctor to justify non-compliance with the guidelines in a serious case. The usual range of sanctions described in paras 35-37 would apply, including the ultimate sanction of deregistration in an extreme case.

Recommendation 4

The *Medical Practitioners Act 1970 (Vic)*, the *Medical Practitioners Act 1938 (NSW)* and the *Medical Practitioners Registration Act 1930 (ACT)* should each be amended to provide specifically that professional misconduct includes a failure to provide adequate information to a patient concerning a proposed treatment or medical procedure.

FOOTNOTES

1 . *Consent to Medical and Dental Procedures Act 1985 (SA)*. This Act protects medical practitioners from criminal and civil liability in respect of a medical procedure if -

the procedure is reasonably appropriate in the circumstances having regard to medical... standards;

the procedure is carried out in good faith and without negligence; and

the patient, being a competent adult or a minor covered by the Act, consents. 'Consent' is defined to mean 'an informed consent given after proper and sufficient explanation of the nature and likely consequences of the procedure'.

2. *Mental Health Act 1986 (Vic)*; *Mental Health Act 1983 (NSW)*. These require that certain patients be given structured information before they undertake psychosurgery, electro-convulsive therapy and certain non-psychiatric treatment. The *Mental Health Act 1983 (ACT)* has no informed consent provisions.

3. Report of the Working Party on Consent to Treatment, South Australia, December 1983, 49.

4. Section 55 (psychosurgery) and Section 72 (electro-convulsive therapy). Other requirements are that the medical practitioner should not have an undisclosed financial interest in the hospital where the treatment is to be performed; that the patient has the right to obtain legal and medical advice and to be represented before consenting; that the patient may withdraw from treatment at any time, and that the patient has been given a statement in the prescribed form of the patient's rights.

5. *Fellowship Affairs*, October 1988, 5.

6. Mr Peter Read, former adviser on Medicare to the Commonwealth Minister for Health, told the Victorian Commission that under the present fee for service arrangements the standard rebate pays for 5 to 25 minutes of general practitioners' time which allows sufficient time for patients with minor ailments to be given information. If more time is necessary with a patient who needs more discussion, that time can be averaged against shorter consultations. Specialists can claim for either procedures or consultations and rebates should be sufficient to cover the giving of advice. Under the proposed arrangements between the government and the College of General Practitioners, the content based descriptors specifically include the provision of advice to the patient and/or relatives.

7. Doveton-Hallam Community Health Centre suggested that doctors will value this education as it will give them increased confidence in their abilities in this area and lessen what doctors tend to perceive as difficult and undesirable aspects of their work.

8. M Somerville, 'Informed Consent: An Introductory Overview', *Informed Consent*, Victorian Law Reform Commission Symposia Papers, Globe Press, Melbourne, 1987, 3.

9. Quality assurance programs in general are supported by the health care professions, hospitals and government. The Victorian Health Minister recently commissioned a Task Force to report on quality assurance: *Quality Assurance and Health Care in Victoria*, Report to Minister for Health from the Task Force on Quality Assurance, Health Department, June 1987.

10. Much of this work is already being done in hospitals particularly those which are members of the Victorian Hospitals Association.

11. Dr N Hicks has suggested that it is the smaller private hospitals, nursing homes and rural hospitals which might need to consider protocols further: N Hicks, 'Structural Conditions for Informed Consent', *Informed Consent*, Victorian Law Reform Commission, Symposia Papers, 19.

12. N Hicks, n 11, 19.

13. The Health Issues Centre in Victoria has issued a wall chart and a series of publications on these matters.

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14. There are numerous developments in this area: pamphlets about specific illnesses and treatments have been developed by some hospitals and Royal Colleges. Some doctors prepare their own information sheets. Consumer groups, information resource collectives, self-help groups and community health centres all produce a range of material. Much of this was developed in response to a lack of verbal information, but it is also very useful as an ancillary to information doctors give to patients.

15. At the Huntington's Disease Unit at Lidcombe Hospital, New South Wales, a social worker often attends doctor/patient consultations and assists in both ensuring that patients fully understand the information they are given and in helping them to come to terms with it. Similar systems prevail in other hospitals. Nurses are central figures in patient care and patients often see them as more 'available' (more empathetic and approachable) for information.

16. Nurses are questioning their legal liability when providing information not provided by the care-giver. (Consultation: Victorian Nursing Council.) The South Australian Health Commission's Working Party on Consent to Treatment reported that consent was obtained in varied ways, both within and between hospitals. (South Australian Health Commission, *Report of the Working Party on Consent to Treatment*, SAHC, Adelaide, 1983.) Residents have registered their concern when patients arrive in hospitals for major procedures and do not know why. This is confusing for junior staff who are not in a position to 'require' better procedures from their seniors. (Consultations with Victorian Commission).

17. The definition of 'professional misconduct' in the New South Wales legislation already includes any conduct that demonstrates a lack of adequate knowledge, experience, skill, judgment or care by the practitioner in the practice of medicine.

Appendix 1 - The Law Relating To Consent To Medical Procedures

Causes of action

There are at least three, and possibly four, causes of action on which a person may rely in complaining of a doctor's failure to provide adequate information concerning a medical procedure. The first is *breach of contract*; the second, *trespass*; and the third, *negligence*. A fourth possibility - *breach of fiduciary duty* - has been raised in England, but so far without success. This duty is supposed to arise from the special relationship which exists between doctor and patient, requiring the doctor to make full disclosure to the patient.

Breach of contract

The details of the contract between doctor and patient must generally take the surrounding circumstances and the nature of the particular relationship into account. However, it seems reasonably clear that there is an implied term in this contract that the doctor must use reasonable care and skill in treating the patient. In this context, treatment includes the provision of information to the patient to enable him or her to make an informed decision about the relevant medical procedure. Patients rarely sue doctors for breach of contract alone, although breach of contract is often pleaded as an alternative to negligence.¹ The main reason is that it seldom offers a benefit to the patient concerned over a claim in negligence. An action in contract may be more difficult to establish than one in negligence. In each action negligence must be proved, but in an action in contract the patient must also establish that there was a contract with the doctor.

Trespass

It is clear that if a doctor undertakes a medical procedure on a patient without the patient's consent, the doctor is guilty of an assault (or more technically, a battery) on the patient.² An action in trespass may be brought in such a case.

For the purpose of an action in trespass, if the patient consented in broad terms to the relevant medical procedure, failure to provide information in relation to a risk inherent in the procedure is not normally regarded as denying the reality of the consent. As the Canadian Chief Justice, Mr Justice Laskin, said in a recent case:

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... [U]nless 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.³

However, a South Australian case suggests that there may be some cases in which consent is lacking, even though the patient knows about the general nature of the procedure. In *D v S*,⁴ the patient had a breast reduction operation to diminish the size and weight of her breasts. The patient was concerned that the operation would cause scarring but the doctor assured her that scarring was unlikely and, if it occurred, would be superficial and would soon fade. On the basis of that statement, the patient agreed to the operation. In fact, the breasts were grossly and permanently scarred and the nipples were relocated unevenly. She suffered pain and lasting embarrassment. She was successful in her claim for damages for battery as well as negligence. The court held that her consent to the operation was not a true consent because the doctor had not told her about the procedure and risks of the operation.

Negligence

If a doctor treats a patient negligently and causes the patient injury, the patient has a right of action in negligence. The negligent act is usually found in the medical procedure. However, a failure to provide information to a patient about the procedure and the risks associated with it may also amount to negligence. Most actions alleging that doctors failed to inform patients sufficiently have, in fact, been brought in negligence.

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The principal question in negligence is whether the doctor was in breach of the duty to exercise reasonable care and skill in the provision of professional advice and treatment. Courts in Australia, as well as in England and New Zealand, have said that a doctor's general duty to act reasonably includes a duty to provide adequate information. The latter is not a separate duty.⁵ As Lord Diplock said in *Sidaway's* case:

In English jurisprudence the doctor's relationship with his patient which gives rise to the normal duty of care to exercise his skill and judgment to improve the patient's health ... has hitherto been treated as single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment... This general duty is not subject to dissection into a number of component parts to which different criteria of what satisfy the duty of care apply, such as diagnosis, treatment, advice (including warning of any risks of something going wrong however skilfully the treatment advised is carried out).⁶

Cox J made the same point in *Gover v South Australia and Perriam*:

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.⁷

And in New Zealand, Mr Justice Woodhouse said in *Smith v Auckland Hospital Board* that providing balanced information and warnings about risks inherent in proposed treatment:

must involve the doctor in the same exercise of judgment founded upon the same medical experience and knowledge as he exercises in the field of technique. In this area of his responsibility, therefore, his duty of care should logically be measured by the same standards and upon the same principles.⁸

The contrary view - that a doctor's duty to take reasonable care in relation to the provision of information is a separate or different duty from that in relation to diagnosis and treatment - has been adopted in a number of American decisions.⁹ 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'.

This emphasis on the patient's rights developed from a statement of Mr Justice Cardozo in *Schloendorff v Society of New York Hospital*¹⁰ that '[e]very human being of adult years and sound mind has a right to determine what should be done with his own body'. On this basis, a patient should not be given medical tests or treatment without the patient's informed consent. A patient has a right to be given information about the nature and implications of any proposed procedure, including material risks, complications and side-effects. Without that information, a patient is incapable of giving an informed consent. This in turn has led to the suggestion that, in relation to the giving of information to patients, a doctor's duty to exercise reasonable care must be judged by a different, more patient-oriented standard than other aspects of a doctor's conduct. As in England and Australia, a doctor's conduct is judged by the standard of whether the doctor acted reasonably - that is, as a reasonable doctor would have done in the circumstances. The American doctrine of informed consent has not been adopted in England or Australia but it has had some influence on the development of the law in those jurisdictions.

Standard of care: reasonable care. In Australia, as in England, the standard of care required of a doctor in relation to information-giving is the same as that required in relation to diagnosis and treatment. It is the standard that is to be expected of an 'ordinarily careful and competent practitioner of the class to which the practitioner belongs'.¹¹ This standard is analogous to that expected of any person who possesses special skills or competence. It is 'the standard of the ordinary skilled man exercising and professing to have that special skill'.¹² The same standard applies to all professional people in an advisory position, such as lawyers and accountants.

Although English courts have adopted a negligence approach they have tended to place greater emphasis on the practice of the average doctor, or standard medical practice, as evidence of what is reasonable. At its most extreme, the decision whether a doctor was negligent in failing to provide adequate information would be judged almost entirely on the basis of expert testimony from other doctors, or other members of a particular specialty, on their practice in relation to the provision of information. If a responsible body of professional opinion is proved by

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such evidence, and the doctor acted according to that opinion, then the doctor was not negligent. This is summed up in the 'Bolam test':

The test [in determining the standard of care required of a doctor in advising and treating his patient] is the standard of the ordinary skilled man exercising and professing to have that special skill ... it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.¹³

Later cases have shown a divergence of views. This is illustrated by the different approaches of Lord Diplock and Lord Bridge on the one hand, and Lord Scarman on the other, in *Sidaway's* case. Lord Diplock said:

In matters of diagnosis and the carrying out of treatment the court is not tempted to put itself in the surgeon's shoes; *it has to rely upon and evaluate expert evidence*, remembering that it is no part of its task of evaluation to give effect to any preference it may have for one responsible body of professional opinion over another, provided it is satisfied by the expert evidence that both qualify as responsible bodies of medical opinion ... [T]o decide what risks the existence of which the 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 as 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.¹⁴

Lord Bridge of Harwich expressed a similar view:

... a decision what degree of disclosure of risks is best calculated to assist a particular patient to make a rational choice as to whether or not to undergo a particular treatment must primarily be a matter of clinical judgment. It would follow from this that the issue whether non-disclosure in a particular case should be condemned as a breach of the doctor's duty of care is an issue to be decided *primarily on the basis of expert medical evidence*.¹⁵

Statements such as these have sometimes been interpreted as leaving the determination of whether the doctor acted 'reasonably' entirely to the medical profession and to undervalue the right of the patient to be given information and to participate in making his or her own medical decisions. Recently, some judges have openly criticised that approach. Lord Scarman said in *Sidaway*:

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. In short, the law imposes the duty of care: but the standard of care is a matter of medical judgment... The implications of this view of the law are disturbing. It leaves the determination of a legal duty to the judgment of doctors.¹⁶

A number of North American judges have made similar criticisms of the principle they see as underlying the English cases. In *Reibl v Hughes*, for example, Mr Justice Laskin said that he was not prepared:

to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty.¹⁷

Australian courts have emphasised that whether a doctor has acted reasonably in a given case cannot be determined solely by reference to what an average doctor, or an average specialist, would do in particular circumstances, nor to what is standard medical practice. It is for the *court* to decide, on the basis of all of the evidence before it, whether the doctor acted reasonably in the circumstances. As Mr Justice King said in *F v R*:

The ultimate question ... 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.¹⁸

The testimony of other doctors, or other specialists, as to their own practices, or standard medical practice, will obviously be substantial evidence in deciding what is reasonable, but it is not conclusive on the question whether

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the information was adequate. Whatever the general practice of medical practitioners, the court may find that a particular practice was unreasonable given the circumstances of the patient in question.

Risks that should reasonably be discussed. The risks that doctors should reasonably discuss with patients are those that are material. In Australia, England and most North American jurisdictions, matters are material if they 'might influence the decisions of a reasonable person in the situation of the patient'.¹⁹ If the risk in question concerned harm or injury so slight, or so unlikely to occur, that no reasonable person would be influenced by it, then that risk need not be discussed. As Mr Justice Tadgell said in a Victorian case in 1988, a doctor is not negligent in not volunteering information that would not have influenced the given patient in deciding about, or consenting to, a recommended medical procedure, or would not have influenced an ordinary person in the patient's position.²⁰

In some recent North American decisions, a different test of materiality has been suggested. Courts have suggested that the question is not whether a reasonable person in the patient's position might have been influenced by the risks, but rather whether *the particular patient* might have been influenced by the risk if told about it. This would mean that in deciding the material risks that should be discussed with a patient, doctors must take into account the personal circumstances of the patient, some of which may not be known to them, but in relation to which they should have made inquiries. This involves the notion of 'constructive knowledge' embodied in the statement of the Supreme Court of Canada in *Reibl v Hughes* that:

what the doctor knows or should know that the particular patient deems relevant to a decision whether to undergo prescribed treatment goes equally to [the doctor's] duty of disclosure as do the material risks recognised as a matter of required medical knowledge [emphasis added].²¹

For example, if a patient's superannuation benefits will vest in 18 months time, that may affect the decision of that patient whether to have a non-essential operation or to defer it. The relevance of such personal matters in determining which risks are 'material' in a particular case requires evidence, not only from members of the medical profession on their general information-giving practices, but also from the patient and his or her family about matters of particular concern to the patient.

In *Reibl v Hughes*, the patient had carotid artery disease. The doctor recommended an operation to reduce the risk of the patient suffering a stroke some time in the future. The operation was not expected to cure the patient's headaches, which were the reason for his consulting the doctor, but the patient did not appreciate this. The operation also carried a 10% risk of causing a stroke, a risk which was not disclosed to the patient. The patient was entitled to pension benefits if he worked for another 18 months. The patient suffered a stroke after undergoing the operation. The Supreme Court of Canada found that this risk should have been disclosed as it would, in all the circumstances, including the patient's financial circumstances, probably have influenced the particular patient to refuse the operation.

Most North American courts have refused to go as far as the Supreme Court of Canada in *Reibl v Hughes*. Although they have focused on the patient's right to be given information, the materiality of the risks has been determined objectively, by reference to the standard of what a reasonable patient would have considered significant, rather than subjectively, by reference to the concerns of the particular patient. They have said that the latter approach would impose an unrealistically high obligation on doctors, requiring them to second-guess the patient and may leave the doctor at the mercy of a patient's hindsight. North American courts have, almost without exception, rejected the particular patient test.

Relevant factors in determining reasonable risks. In all jurisdictions, the question whether a particular risk is material must be determined in each case as a matter of fact in all the circumstances. The factors that may be relevant in deciding whether a particular risk is material include the following (which obviously overlap):

*the personality and temperament of the patient and the patient's attitude.*²² As Mr Justice Cox said in *Gover v State of South Australia and Perriam*: '[A doctor] is obliged to act reasonably in the circumstances, and the circumstances will include a fair appraisal of [the] patient's intelligence and temperament and apparent understanding, made in the light of the simplicity or complexity of the recommendation [the doctor] is making.'²³

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whether the patient wants information. If a patient is apparently keen to be given more information, rather than seeking reassurance, more information should generally be given. If, on the other hand, the patient does not want information, the doctor is obviously not required to force it upon the patient: 'Many people are prepared to place themselves in the hands of their doctors and to leave all decisions to them'.²⁴ The patient can be said to be exercising autonomy by requesting not to be given information and by accepting the decision of the doctor. However, doctors are nevertheless still required to give patients basic information and, in some cases, they may have difficulty in deciding how much to tell a patient who does not want fuller information. For example, if the choice for the patient is between a lumpectomy and a mastectomy, how much information should the doctor give about the two operations if the patient says 'I'll leave it to you Doctor'? In deciding whether the patient wants information, as in other matters, the doctor must exercise reasonable care and judgment.²⁵

whether the patient asks questions. North American courts have said that a doctor's duty to give information is not altered by the patient asking questions. A doctor is an expert and should therefore be required to give all the relevant information whether it is specifically requested or not. Many patients may be unable to identify the relevant questions to ask and 'a rule which presumes a degree of sophistication which many members of society lack is likely to breed gross inequities'.²⁶ In addition to not knowing the relevant questions to ask, patients may not wish to show their ignorance or they may be too ill or overawed by their situation to ask questions. In Australia and England, however, courts have said that more information should be given if patients ask questions. The patient's questions indicate to the doctor additional information that is 'material' for that patient in deciding whether to undertake the recommended procedure and 'A direct question would have called for an answer telling of the risk, however slight'.²⁷

the patient's level of understanding. A doctor need not 'cross-examine his patient exhaustively to ensure that she both understands and will remember his advice' but should give information that the doctor thinks that the patient will understand after 'a fair appraisal of his patient's intelligence and temperament and apparent understanding, made in the light of the simplicity or complexity of the recommendation he is making'.²⁸

the nature of the treatment. More drastic treatment (such as major surgery) requires more information.²⁹ If the treatment is necessary to preserve the patient's life or health, however, it may require less explanation than less urgent treatment, even if it is relatively serious. Thus, in the South Australian case *Gover v State of South Australia and Perriam*,³⁰ a patient undertook eye surgery, principally for cosmetic reasons, to reduce her 'baggy' eyelids. One factor that was held to be relevant in deciding what information she should have been given was that eye drops or ointment were alternative treatments so far as the medical condition of the eye was concerned. The 'bagginess' of her eyelids was not unduly gross and if she had known that her medical condition could be treated non-surgically, that might have influenced her decision whether to agree to surgery. Similarly, in the Canadian case *Haughian v Paine*,³¹ a patient agreed to a laminectomy and discotomy recommended by his surgeon to relieve pain and disability in his right arm. This operation was not immediately necessary and an alternative, at least for the time being, was 'conservative management' - supervised rest, traction, muscle therapy and analgesic medication. The court held that as the operation was not essential to preserve the patient's life or health, he should have been given this information and allowed to decide for himself.

the magnitude of the possible harm. There is a greater duty to provide information about the possibility of serious harm even if the chance of it occurring is slight.³² A doctor should discuss a risk of death, stroke, paralysis, blindness or other serious complication with a patient even if there is only a slight chance of the risk eventuating. Thus, in the eye surgery case referred to above, the court said that the risk that the operation might cause blindness should have been mentioned to the patient: the risk of blindness was very small indeed, but the magnitude of such a complication meant that the decision should properly have been left to the patient herself.³³ Similarly, Mr Justice Zelling said in another case in which the patient suffered eye damage as a result of a drug to treat severe mental illness: 'In my view, no doctor is entitled to give a patient treatment which may blind or seriously damage her eyesight without first discussing it with the patient and obtaining her consent to the treatment'.³⁴ However, if the chance of the risk eventuating is so slight that no reasonable person would be influenced by it, the risk need not be mentioned to the patient.

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the likelihood of the risk. There is a greater obligation to discuss risks that are more likely to occur than those that are rare. This applies even if the harm is relatively slight. However, it is probably not generally necessary for a doctor to discuss with a patient risks that are inherent in any operation, such as the general risks of anaesthesia or infection after surgery, because patients are assumed to know these risks or to consider them too remote to be significant.³⁵

the general surrounding circumstances. The extent of the duty to give information may be affected by emergency conditions, or the absence of the opportunity for detached reflection or calm counselling, and the existence of alternative sources of advice.³⁶ A doctor may proceed to treat a patient without giving information or obtaining consent if it is an emergency.³⁷ The courts have not defined what constitutes an emergency, in particular whether it must be threatening to the patient's life or whether it is sufficient that there is a risk of grave physical or mental injury to the patient, or both.³⁸ In practice, doctors often face difficult decisions in situations which might not be life threatening. In judging the doctor's conduct in such circumstances, the principal question will be whether the doctor's actions accorded with what a reasonable doctor would have done in similar circumstances.

the doctor's belief on reasonable grounds that the patient's health or welfare might be seriously harmed by being given the information. If a patient is of a nervous or anxious disposition, a doctor may justifiably withhold or, in particular, refrain from volunteering, information 'when he judges on reasonable grounds that the patient's health, physical or mental, might be seriously harmed by the information',³⁹ or if the doctor 'reasonably judges that a patient's temperament or emotional state is such that he would be unable to make the information a basis for a rational decision'.⁴⁰ The reference to 'reasonableness' indicates that the doctor's belief about the risk to the patient's health is judged objectively. It is not sufficient that the particular doctor believed that the patient's health was at risk. The case must be such that a reasonable doctor would have held that belief.

Doctors have some discretion to withhold information on such grounds even if a patient asks questions. Chief Justice King said in *F v R*, that even if a patient directly requests information, a doctor's duty to act in the patient's best interests 'may justify or even require an evasive or less than fully candid answer even to a direct request',⁴¹ especially if the question arises from a desire for reassurance rather than information. However, the extent to which doctors may justifiably withhold information which they believe might harm the patient's welfare is strictly limited.⁴² Chief Justice King stressed that a doctor should not lightly decide that a patient should not be fully informed. 'The governing consideration is the right of every human being to make the decisions which affect his own life and welfare and to determine the risks which he is willing to undertake'.⁴³ If a doctor withholds information from a patient on the ground that that was necessary in the patient's best interests, the doctor must have reasonable grounds for that belief.

Causation. A patient can recover damages for negligence only if it is proved that the injury was in fact caused by the doctor's negligence. In the case of a failure to provide relevant information, the plaintiff must prove that, if properly informed of the treatment's implications or its associated risks, he or she would not have taken the treatment which caused the injury and that a risk that should have been disclosed in fact caused the injury. The last two matters are questions of causation. Even if the doctor is found to have been negligent in failing to provide adequate information, the patient may fail on the ground that the doctor's negligence did not cause the relevant injury.

In Australia, the question whether the doctor was negligent is determined by reference to an objective test. The question is whether the doctor acted reasonably in the circumstances, and whether the risk in question would have been material to a reasonable person in the patient's position. If the doctor is found to have been negligent, the next issue - whether that negligence caused the patient's injuries - is decided by a subjective test.⁴⁴ 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 a consideration of a reasonable person in the patient's position.

This issue has rarely been the subject of a judicial decision in Australia as plaintiffs have almost invariably failed at the preliminary hurdle of proving that the doctor acted in breach of the doctor's duty of care to the plaintiff. In North America, on the other hand, the standard for the provision of information is generally more subjective, but

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the test for causation is objective; it is determined by reference to the reasonable, and not the particular, patient.⁴⁵ In practice, therefore, the result may not be greatly different.

The interaction of the standard of information-giving and the test of causation may be illustrated by a recent Victorian case involving a failed tubal ligation. Mr Justice Tadgell said that the defendant gynaecologist had not acted unreasonably in not advising the patient and her husband of the 'infinitesimal or slight prospect of the failure of a tubal ligation' since that advice would not have influenced 'ordinary persons in their position'.⁴⁶ In reaching that conclusion, the judge took into account the following matters:

the plaintiff later underwent a similar operation on her fallopian tubes (a laparoscopic tubal ligation) which carries a similar risk of failure, and neither she nor her husband used other contraceptive methods after the operation;

the plaintiff had the second operation despite the fact that she said in relation to the first operation that she would not have undergone it, with full anaesthetic, if there was any chance of failure, however slight.

Had the judge found that the doctor did not act reasonably because the risks were material and should have been discussed, these matters would have been equally relevant to the causation question: would the plaintiff (or, on an objective test, a reasonable person in the plaintiff's position) have undertaken the procedure if informed of the risk of recanalisation?

As the common law develops, judges who believe that doctors should give more information to their patients may be more inclined to find that the doctor did not act reasonably and should have given more information. Even so, plaintiffs may fail on the causation question.

Conclusion

There has clearly been some difference in emphasis between the case law in England, Australia and North America. The English and Australian cases have adopted a negligence approach. The issue is whether the doctor acted reasonably in providing information to the patient. One question is whether the doctor did as other doctors would have done in similar circumstances. Another is whether the risk was material, that is, whether it would have influenced a reasonable person in the position of the patient in deciding whether to undertake the procedure in question. But the overriding question is whether the doctor acted reasonably in all the circumstances, which is a question for the court to decide on the basis of all the evidence. If the doctor is found not to have acted reasonably - to have been negligent - the patient must then prove causation. This means that the patient would not have undertaken the procedure if he or she had been informed of that risk, and the risk that should have been discussed in fact caused the patient's injury. Since most patients have in practice not been able to prove that the doctor was negligent, courts have rarely had to consider questions of causation. It appears, however, that the test for determining causation is subjective - would the particular plaintiff have been influenced by knowing that risk?

In North America, on the other hand, the initial inquiry is more subjective; it focuses on the patient's right to information, rather than on whether the doctor acted reasonably. Expert evidence of standard medical practice is therefore much less important. But if the patient is able to establish that he or she was not given information to which he or she was entitled, the question whether that would have influenced the patient not to have the procedure is determined by considering whether the information that should have been given would have had that effect on a reasonable person.

FOOTNOTES

1. The Medical Defence Association of Victoria has advised of many allegations of breach of contract in cases that have not reached the courts.

2. A surgical operation or other medical procedure involving the direct touching of a patient, if performed without the patient's consent, constitutes a trespass. In exceptional circumstances, such as where the patient is unconscious and immediate treatment is required to prevent, or minimise, the risk of grave physical and/or

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mental harm to the patient, a doctor may be justified in proceeding without the patient's consent. In normal circumstances, however, the doctor must obtain the patient's consent or risk liability in trespass.

3. *Reibl v Hughes* (1980) 114 DLR (3d) 1, 10-11.

4. (1981) 93 LS (SA) JS 405.

5. Although the Federal Court of Australia held in *Golski v Kirk* (1987) 14 FCR 143, that a doctor's breach of the duty to take care in warning or advising on medical treatment gives rise to a separate cause of action from that arising from a breach of the duty to take care in relation to treatment, that does not mean that they are separate duties. The reason why the different breaches may lead to separate causes of action is not because they arise from breaches of different duties, but because they are separated in time and, if proved, may give rise to significantly separate and additional awards of damages. A patient who is able to prove that he or she would not have undertaken the operation recommended by the doctor if properly informed of the risks is entitled to compensation on that ground as well as the compensation which would be awarded for negligent performance of the operation itself.

6. *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Mandsky Hospital and others* [1985] 1 AC 871, 893.

7. (1985) 39 SASR 543, 551.

8. [1964] NZLR 241, 247: later appealed [1965] NZLR 191.

9. 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.

10. (1914) 211 NY 125; 105 NE 92, 93.

11. *F v R* (1983) 33 SASR 189,190 (King CJ).

12. *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118, 121 (McNair J); confirmed and applied in *Gold v Haringey Health Authority* [1987] 2 All ER 888, 893-4 (Lloyd LJ), 896 (Stephen Brown LJ).

13. *Bolam v Friern Hospital Management Committee*, n 12, 586 (McNair J).

14. *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital and Others* n 6, 895 (emphasis added).

15. n 14, 900.

16. n 14, 881-2.

17. n 3, 13.

18. n 11, 194.

19. *F v R*, n 11, 192 (King CJ) (emphasis added).

20. *Petrunic v Barnes*, (1988) *Australian Torts Reports*, 80-147.

21. n 3, 12.

22. *F v R*, n 11, (Bollen J).

23. n 7, 558.

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24. *F v R*, n 11, 193 (King CJ).
25. *F v R*, n 11, 192 (King CJ).
26. *Canterbury v Spence*, (1972) 464 F 2d 772, 783, n 36.
27. *F v R*, n 11, 207 (Bollen J).
28. *Gover v State of South Australia and Perriam*, n 7, 558 (Cox J).
29. *F v R*, n 11, 192 (King CJ).
30. n 7.
31. (1987) 40 CCLT 13.
32. *F v R*, n 11, 192 (King CJ); *Battersby v Tottman and State of South Australia* (1985) 37 SASR 524, 542 (Jacobs J).
33. *Gover v State of South Australia and Perriam*, n 7, 563. In fact, the possibility of blindness was not then generally recognised as a risk of the eye operation in question, so the surgeon was found not to have been negligent in not discussing it with the patient.
34. *Battersby v Tottman*, n 32, 534.
35. *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital*, n 6, 897 (Lord Bridge of Harwich).
36. *F v R*, n 11, 193 (King CJ).
37. *F v R*, n 11, 193 (King CJ).
38. The *Consent to Medical and Dental Procedures Act 1985* (SA) enables emergency medical procedures to be carried out on persons unable to consent if the doctor 'is of the opinion that the procedure is necessary to meet imminent risk to the person's life or health': section 7(2)(b)(i).
39. *F v R*, n 11, 193 (King CJ) (emphasis added); *Battersby v Tottman and State of South Australia*, n 32, 527 (King CJ).
40. *F v R*, n 11, 193 (King CJ) (emphasis added).
41. n 11, 192.
42. Lord Denning's endorsement (*Hatcher v Black*, *The Times*, 2 July 1954) of a doctor's right even to lie to a patient in response to a direct question, when the doctor believed that to be in the patient's best interests, has been modified by *Sidaway* (n 6). Similarly, it was held in New Zealand, in *Smith v Auckland Hospital Board* ([1965] NZLR 191, 198) that if a patient asks about the risks of an operation, those questions should be answered carefully (although not necessarily truthfully), subject to the doctor's assessment of the likely effect of the information on the patient's health.
43. *F v R*, n 11, 192-3.
44. English courts have also applied a subjective test in determining causation in informed consent cases: *Chatterton v Gerson* [1981] 1 QB 432; *Hills v Potter* [1983] 3 All ER 716 (QB).
45. See, for example, *Canterbury v Spence*, n 26, 791: 'What a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance'. In *Reibl v Hughes*, n 3, the Supreme Court of Canada also rejected the subjective test of causation. It would be too favourable to plaintiffs who would always

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have the benefit of hindsight and would claim that their decision would have been different if they had been properly informed of the risks.

46. *Petrunic v Barnes*, n 20, 67, 329.

Appendix 2 - Proposed Draft Legislation

VICTORIA

Information on Medical Procedures Act 1989

The Parliament of Victoria enacts as follows:

Purpose

1. The purpose of this Act is to amend the *Wrongs Act 1958* and the *Medical Practitioners Act 1970* in relation to the relevance, in actions against doctors or an inquiry by the Medical Board, of applicable standards or guidelines issued by the National Health and Medical Research Council.

Amendment of the Wrongs Act 1958

2. *The Wrongs Act 1958* is amended by inserting after Part 11A the following Part:

"PART 11B - ACTIONS AGAINST DOCTORS BASED ON FAILURE TO PROVIDE INFORMATION

Courts must take account of National Health and Medical Research Council standards or guidelines:

14E. In an action against a medical practitioner for damages for injury based on failure to provide adequate information to a patient, a court must take into account any applicable standard or guideline issued by the National Health and Medical Research Council."

Amendment of the Medical Practitioners Act 1970

3. *The Medical Practitioners Act 1970* is amended by inserting the following section:

"16(1A) In deciding whether such a failure has taken place the Board must take into account any failure by the medical practitioner, without reasonable excuse, to provide information to a patient in accordance with any applicable standard or guideline issued by the National Health and Medical Research Council."

AUSTRALIAN CAPITAL TERRITORY

Law Reform (Miscellaneous Provisions) Amendment Act 1989

No. of 1989

An Act to amend the *Law Reform (Miscellaneous Provisions) Act 1955* and for related purposes.

The Legislative Assembly for The Australian Capital Territory enacts as follows:

Short title

1. This Act may be cited as the *Law Reform (Miscellaneous Provisions) Amendment Act 1989*.

Amendment of the Law Reform (Miscellaneous Provisions) Act

2. The *Law Reform (Miscellaneous Provisions) Act 1955* is amended by inserting after Part IV the following Part:

"PART IVA - ACTIONS FOR CERTAIN MEDICAL NEGLIGENCE

Actions for certain medical negligence

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"13A. In an action against a medical practitioner for damages for injury founded on the negligent failure of the practitioner to give adequate information to a patient, the matters that the court must take into account in determining whether the information given was adequate include any applicable standard or guideline published by the National Health and Medical Research Council and notified in the *Commonwealth of Australia Gazette*."

Amendment of the Medical Practitioners Registration Act

3. Section 30 of the *Medical Practitioners Registration Act* 1930 is amended by:

(a) omitting from paragraph (5)(b) "and";

(b) Inserting after paragraph (5)(b) the following paragraph:

"(ba) failing, without reasonable excuse, to ensure that, in relation to any medical procedure or treatment, adequate information is given to a person whose consent to the procedure or treatment is necessary;" and

(c) adding at the end the following subsection:

"(6) In determining for the purposes of paragraph 5(ba) whether information given was adequate, the matters to be taken into account include any applicable standard or guideline published by the National Health and Medical Research Council and notified in the *Commonwealth of Australia Gazette*".

NEW SOUTH WALES

Short title

1 . This Act may be cited as the Medical Practitioners (Informed Decisions) Amendment Act 1989.

Commencement

2. This Act commences on a day or days to be appointed by proclamation.

Amendment of Medical Practitioners Act 1938 No. 37

3. The Medical Practitioners Act 1938 is amended as set out in Schedule 1.

Schedule I - Amendments

(Sec. 3)

(1) Section 27 (Definitions) -

After paragraph (a) of the definition of 'professional misconduct' in section 27 (1), insert:

(a1) *refusing*¹ or failing, without reasonable cause, to *ensure*² that adequate information concerning medical treatment proposed to be carried out on a patient by the practitioner is provided to the person *by whom consent to the treatment is to be given*³;

(2) Section 52A -

After section 52, insert:

Informed decisions about medical procedures etc. - admissibility of guidelines

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52A. (1) This section applies in civil or disciplinary proceedings against a medical practitioner involving the alleged refusal or failure of the practitioner to ensure adequate information concerning medical treatment proposed to be carried out by the practitioner is provided before consent to the carrying out of the treatment is given.

(2) The court or disciplinary body must (in determining whether the person was adequately informed in the circumstances) have regard to any applicable guideline or standard issued by the National Health and Medical Research Council and published in the Commonwealth of Australia Gazette and in force at the time of the alleged refusal or failure.

(3) Such guidelines or standards are accordingly admissible in evidence.⁴

(1) "Refusing" has been included because it is used with "failing" in another paragraph of the same subsection that prescribes grounds of professional misconduct.

(2) "Ensure" is used to cover the possibility that a practitioner may properly rely on information given by another person.

(3) Note that the information is to be given to the person by whom consent must be given, who may not necessarily be the patient. See, in particular, section 49 of the Minors (Property and Contracts) Act 1970, Part 5 of the Disability Services and Guardianship Act 1987 and Division 3 of Part 10 of the Mental Health Act 1983.

(4) This section could equally well be located in the Evidence Act 1898.

Appendix 3 - Consultations

Victoria

Association of Medical Directors of Victorian Hospitals

Australian Association of Surgeons

Australian Medical Association

Collective of Self-help Groups (COSHG)

Doctors' Reform Society

Health Department, Review of Health Legislation

Health Issues Centre

Medical Board of Victoria

Medical Defence Association of Victoria

Royal Australasian College of Physicians

Royal Australian College of General Practitioners

Royal Australian College of Obstetricians and Gynaecologists

Royal Australasian College of Surgeons

Victorian Hospitals' Association Limited

Victorian Nursing Council

Women's Health Resource Collective

New South Wales

Australian Consumers' Association

Department of Health

Huntington's Disease Association

Medical Complaints Unit, Department of Health

Medical Defence Union (NSW)

Medical Defence Union (UK)

National Health and Medical Research Council

New South Wales Cancer Council

New South Wales College of Dermatologists

NSW Law Reform Commission: REPORT 62 (1989) - INFORMED DECISIONS ABOUT MEDICAL PROCEDURES

New South Wales College of General Practitioners

New South Wales College of Surgeons

New South Wales College of Surgeons, Faculty of Anaesthetists

Public Interest Advocacy Centre

Voluntary Euthanasia Society

Appendix 4 - Submissions

Medical Practitioners

General Practitioners

Anonymous, forwarded by Mr D M Cameron, Federal Member for Moreton, Qld

Dr W S Jame, Vic

Dr S Moraitis, Vic

Dr P Nisselle, Vic

Dr Z Stelmach, Vic

Dr B Vaughan, Vic

Specialists

Anonymous, Urologist, forwarded by Mr D M Cameron, Federal Member for Moreton, Qld

Dr J H Bolton, Vic

Dr E L G Beavis, Vic

Dr J B Drake, Vic

Mr P L Field, Vic

Mr A W Jansz, Vic

Dr M Jelinek, Vic

Ms L McEwan, Vic

Dr M C Moore, SA

Dr I Olver, Vic

Squadron Leader R J Patten, Vic

Dr I G Pettigrew, Vic

Dr B Pollard, NSW

Dr T F Sandeman, Vic

Dr M Tobin, Vic

Medical Profession - Organisations

Colleges

Australian College of Health Service Administrators, NSW

NSW Law Reform Commission: REPORT 62 (1989) - INFORMED DECISIONS ABOUT MEDICAL PROCEDURES

Royal Australian College of Medical Administrators, Victorian State Committee

Royal Australian College of Obstetricians & Gynaecologists

Royal Australasian College of Physicians

Royal Australasian College of Physicians, NSW State Committee

Royal Australasian College of Surgeons

Royal Australian and New Zealand College of Psychiatrists, Victorian Branch

The Royal Australian College of General Practitioners, NSW Faculty

Associations

Australian Association of Surgeons Victorian Committee

Australian Huntington's Disease Association, NSW

Australian Medical Association, ACT

Australian Orthopaedic Association

Australian Society of Anaesthetists, Victorian Section

University Faculties

Professor P J Scott, Department of medicine, University of Auckland, NZ

Hospitals

Dr H E Clifford, General Superintendent, Sydney Adventist Hospital via Private Hospitals Associations of NSW Inc.

Dr B Ford, Caulfield Hospital, Vic

Dr A Kucers, Director of Medical Services, Fairfield Hospital, Vic

Dr J S Yu, General Superintendent, The Children's Hospital NSW

Church & Charitable Private Hospitals Association, Vic

Medical Advisory Committee, Amalgamated Melbourne and Essendon Hospitals

Medical Advisory Committee, The Royal Southern Memorial Hospital, Vic

Medical Director, Public Hospital, Qld

St Vincent's Bioethics Centre, St Vincent's Hospital, Vic

Victorian Bush Nursing Association

Other health care personnel

Ms J Anderson, Nurse

Ms M J Johnstone, Nurse Educator

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Ms I Kearsey, Medical Records Advisor

Ms T Mercovich, Nurse

Mrs P Pickert, Nurse

Mr A Retsas, Nurse Educator

Dr J M Ward, Dentist

Physiotherapists Registration Board of Victoria

Australia Podiatry Association (Vic)

Australian Dental Association, Victorian Branch

Chadstone Community Health Centre Nurses

Social Work Department, Prince Henry's Hospital

Community

Individuals

Mr B Barcan, Vic

Miss D Burn, Vic

Dr R Burns, Vic

Mr M E K Corner, Vic

Mrs J Critchley, Vic

Mr C Duncan, Vic

P A Dunn, Vic

Ms S Dunn, NSW

Mr E Ewing, Vic

Mr J Gerrand, Vic

Ms H Gerstmann, Vic

Mrs M Haig, Vic

Mr A T Kenos, Vic

Dr H Kuhse, Vic

Mr G Moodie, Vic

Ms A L N Riches, NSW

Mrs R Sascon, Vic

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Mrs F L. Sheppee, Vic

Dr R Spillane, NSW

Ms H Strnad, Vic

Professor Emeritus J M Swan, Vic

Mrs U Wilkinson, ACT

Organisations associated with patients

Anti-Cancer Council of Victoria

AIDS Council of New South Wales Inc., NSW

Arthritic Women's Task Force, Vic

Australian Huntington's Disease Association, NSW

Back Pain Association, Vic

Chronic Pain Association, Vic

Co-Care (Back-up Group), Coburg Care Centre Inc., Vic

Consumers' Health Forum of Australia Inc., ACT

Dandenong and Springvale District Health Council, Vic

Doncaster/Templestowe District Health Council, Vic

Doveton-Hallam Community Health Centre, Vic

Haemophilia Foundation of Australia Inc., Vic

Handicapped Citizen's Association Inc., ACT

Health Issues Centre, Health Complaints Advisory Link Line, Vic

Keysborough Women's Group, Keysborough Learning and Drop-in-Centre, Vic

Maternity Alliance, NSW

South-Port Community Health Service, Vic

Sydney Manic Depressive Self Help Group

The Australian Cancer Patients Foundation, Inc., Vic

The Centre Against Sexual Assault (CASA House), Vic

The Family Planning Association of NSW Inc.

Transcultural Health Care Council, Vic

Women's Health Resource Collective, Vic

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Other organisations

Australian Consumers' Association, NSW

Catholic Women's League, NSW

Citizens' Commission on Human Rights, NSW

Council on the Ageing, ACT

Humanist Society of Victoria

Presbyterian Women's Association of Australia, NSW

Public Interest Advocacy Centre, NSW

Right to Life Association, NSW

The Church of Scientology, Vic

Women's Electoral Lobby, Vic

Government and statutory bodies

AHMAC Subcommittee on Women and Health, Department of Community Services and Health, ACT

Commissioner of Health Services, Vic

Complaints Unit, Department of Health, NSW

Director-General of Health Services via Law Department, Tas

Drug Evaluation Branch, Department of Community Services and Health, ACT

Family Law Branch, Attorney-General's Department, ACT

Human Rights and Community Law, Administration Central Office, ACT

Mental Health Services, Dept of Health, North Coast, NSW

Medical Board of Victoria

National Health and Medical Research Council, Medical Research Ethics Committee

National Health and Medical Research Council, Public Health Research and Development Committee

Policy and Administration Community Programs, Department of the Arts,

Sport, the Environment, Tourism and Territories, ACT

Privacy Committee, NSW

Psychosurgery Review Board, NSW

Victorian Ethnic Affairs Commission

Legal

NSW Law Reform Commission: REPORT 62 (1989) - INFORMED DECISIONS ABOUT MEDICAL PROCEDURES

Ms J V Coombs, Barrister, NSW

Ms R Creyke, Australian National University

Ms Judith Fordham, Solicitor, WA

Mr E F Frohlich, Barrister, ACT

Mr J S Grice, JP, Northern NSW Federation of Justices

Mr G V Halliday, Solicitor, ACT

Mr A W McDonald (now the Hon Mr Justice), Vic

Ms K Mack, University of Adelaide

Medical Defence Union, Ltd., NSW

The Hon Sir John Minogue, Vic

The Hon Sir John Norris, Vic

Mr Justice P E Nygh, Family Court of Australia, NSW

Mr P O'Bryan, Solicitor, Vic

Mr C J H Thomson, Australian National University

The Law Society of South Australia

Mental Health Legal Centre Inc., Vic