

## SOME RECENT CASES ON INFORMED CONSENT

### (1) INTRODUCTION

In some common law jurisdictions there has developed a rule that where a patient agrees to medical, surgical or dental procedures but without having first been informed, warned or advised about the procedure to be undertaken, the patient's apparent consent is ineffective. This leaves the medical or dental practitioner involved open at the suit of the patient to an action for battery, which has several procedural advantages for a plaintiff when compared with an action for negligence. As will be seen both actions can be available on the same facts.

The need for a patient to be apprised of certain information about the procedure before an apparent consent can be effective has been called the doctrine of "informed consent". Does it represent the law in Australia today? There have been three relatively recent cases in the courts which have examined this question, two in the Supreme Court of South Australia and one in the Supreme Court of New South Wales.

One striking thing about medical litigation is how rarely a plaintiff succeeds. To win a negligence action the plaintiff must establish all of the elements of the case, most notably, a breach of duty, and the usual yardstick by which the standard of care is gauged to ascertain a breach is the accepted standard of medical practice.<sup>1</sup> This is a daunting task and no wonder plaintiffs have sought to take refuge in torts other than negligence to see if they can ease the heavy burden of establishing the appropriate standard of care and proving the breach of it. *Res ipsa loquitur* may be called in aid in some cases, but apparently not when there is direct evidence of how the allegedly wrongful act occurred.<sup>2</sup>

As virtually all medical treatments, examinations and procedures would be assaults but for the consent of the patient, it is not surprising that enterprising lawyers have seen the tort of battery as ripe for application to what American lawyers would call "malpractice" litigation. If a case can be made out in battery, just about all a plaintiff will have to prove is that there was an intentional touching by the defendant of the plaintiff's body. But the best from the plaintiff's point of view is yet to come. It appears well established that consent is a *defence* to an action in trespass to the person. As such it will have to be proved affirmatively by the defendant.<sup>3</sup>

Thus, where a plaintiff can bring a case in battery it will almost inevitably transfer a large part of the onus of the case onto the defendant, at the same time dispensing with the need to go into evidence of accepted standards of medical practice with the associated practical difficulties of obtaining witnesses. It will also avail a plaintiff of the

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1 See the now famous dictum of McNair J in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118; now it seems universally accepted as a correct statement of the law and discussed infra.

2 *Eg Albrighton v Royal Prince Alfred Hospital* [1979] 2 NSWLR 165 at 169. Yeldham J, refused to apply *res ipsa* where there was direct evidence fit for consideration by a jury.

3 This point is dealt with more fully infra.

possibility of aggravated and other damages transcending the purely compensatory which would not be available in an action based on negligence.<sup>4</sup>

How then does one set about introducing the tort of battery into medical cases? The answer is by the American doctrine of "informed consent". This doctrine postulates that if a patient is not apprised of the risks, alternatives and consequences of a medical procedure, particularly surgery, any "consent" given to it is in form only and ineffective in substance. Thus, the doctor will be open to suit in battery wherein the plaintiff can claim that bodily integrity has been invaded intentionally by the doctor who will be likely to lose the action unless it can be established that before the procedure in question an effective consent was obtained. Almost always negligence will be pleaded as an additional count, specifically a breach of duty by the doctor in failing to obtain an effective consent or failing to warn, advise or inform the patient adequately before the procedure was undertaken.

This kind of legal strategy, focusing as it does on trying to make battery the first string in the legal bow, is well known in America.<sup>5</sup>

The negligence aspect holds that the doctor has a duty founded on the tort of negligence, to warn, advise or inform the patient about what is proposed. As a consequence, apart from the result of failure to inform as an issue in trespass, the same failure to inform might also be a breach of duty, opening the way for a negligence action. The differences in the consequences and requirements of the two actions will be referred to later. That there are two separate causes of action both labelled "informed consent" is not always obvious from the American cases and the literature. Perhaps "informed consent" should be applied exclusively to the battery issue and a term such as "duty to warn and advise" used for the negligence aspect.

## (2) ATTEMPTS TO INVOKE THE DOCTRINE IN AUSTRALIA

There have been at least three important medical negligence cases in Australia in recent years where attempts have been made to sow the seeds of an indigenous doctrine of informed consent, or perhaps more correctly, to transplant the American version. They have met with mixed success.

### (i) *Hart v Herron and Chelmsford Private Hospital*<sup>6</sup>

This mammoth episode of medical litigation ran for 74 sitting days in the Supreme Court of New South Wales before Fisher J (as he then was) and a jury of twelve. It attracted a large newspaper coverage at the time.<sup>7</sup> As the case is unreported the facts have to be gleaned from his Honour's summing up to the jury which runs to 190 pages of transcript.

Hart, a gymnasium proprietor, was forty five years old at the time of the trial. He underwent cosmetic plastic surgery in 1972 but was not

4 This appears to be the combined effect of the decisions of the High Court in *Uren v Fairfax* [1966] 117 CLR 118 and the House of Lords in *Rookes v Barnard* [1964] AC 1192.

5 Eg *Canterbury v Spence* 464 F 2d 772 (1972) building as it does on *Nathanson v Kline* 350 P 2d 1093 (1960) and *Salgo v Leland Stanford Univ* 317 P 2d 170 (1957).

6 Unreported jury trial before Fisher J Supreme Court of NSW No 12781 of 1979. Judgment delivered 11 July 1980.

7 Eg *National Times* 20 July and 27 July 1980.

satisfied with the outcome. From the evidence this appears to have been the origin of a psychiatric disorder of a depressive kind, with accompanying paranoia from which he was suffering. He consulted the defendant Herron, a psychiatrist, about it. He arranged treatment in the Chelmsford Private Hospital which was joined in the action as second defendant. Herron appears to have seen the depression as a psychopathology in need of immediate treatment. It was suggested to Hart therefore that he enter the Chelmsford Hospital for a couple of weeks to have the depression treated. Conversations with Herron at this stage and the subsequent events in the hospital were the crux of Hart's case, so far as it was based on the failure of Herron and the hospital to warn him and advise him and to obtain his consent. There was also a conflict in the evidence of the plaintiff and defendant as to the conversations that passed between them relating to the proposed treatment. Hart was adamant that before hospitalisation he had only a short discussion with Herron who told him nothing about the treatment to be undertaken for the depression. Nor on Hart's evidence did he give consent to any particular form of treatment.

In contrast, Herron's evidence was that he had explained in some detail the proposed treatments of electro-convulsive therapy (ECT — colloquially known as shock treatment) and narco-therapy. With narco-therapy a deep sleep is induced and its object, as is the case with ECT, is to counteract the depressive state which in severe cases can lead to suicide. According to Herron, Hart agreed to these procedures before entering hospital. It appears however that on arrival at Chelmsford, Hart refused to sign a consent form for ECT.

Hart also said the sight of patients in the hospital made him reticent about proceeding with his admission. At that point he was interviewed by a psychiatric nurse Mr Dillworth who had a long conversation with him. Counsel for Herron submitted that part of the conversation was verbal reaffirmation of consent that Hart had previously given to Herron but refused to put his signature to in written form. Hart's evidence was that following a discussion with Dillworth he was offered and accepted a tablet and a glass of water. After taking the tablet everything went blank and he woke up ten days later having been under deep-sleep therapy.

Somehow the narco-therapy had gone awry because when Hart awoke he found himself in the intensive care unit of a public hospital. During the treatment he had contracted pneumonia, pleurisy, cyanosis as a result of respiratory difficulties and anoxia or lack of oxygen as well as deep venous thrombosis. It was also alleged that Hart suffered brain damage due to these complications arising from the narco-therapy.

Hart brought an action, pleading in negligence, battery and false imprisonment, against both Herron and the hospital. He alleged in the pleadings that battery and negligence were constituted, *inter alia*, by the absence of informed consent on his part. Of course other particulars of negligence were pleaded, including one that the procedure was inappropriate to the type of hospital where it was performed and that in the circumstances of the case it would not have been undertaken by a reasonably prudent and skilful psychiatrist such as Herron held himself out to be.

The issues relevant to informed consent were canvassed thoroughly by the trial judge. His appraisal of the law relevant to the case appears principally in two interlocutory judgments given in the absence of the

jury on 23 and 26 June 1980. In the second of these Fisher J considered informed consent as an issue in battery:

“[T]he allegation is that the defendants wrongfully admitted, detained and treated the plaintiff in hospital without his effective consent . . . Consent is also raised in the form of an allegation of failure to exercise reasonable care to obtain a valid and properly informed consent to the treatments proposed to be given . . . Both counsel agreed that the absence of consent was part of the gist of the action in a count for assault. They disagreed as to who bore the onus.”<sup>8</sup>

His Honour concluded that on the basis of the decision of the High Court in *McHale v Watson* (1964) 111 CLR 384 and *Blacker v Waters* (1928) 28 SR(NSW) 206, a decision of the full bench of the Supreme Court of New South Wales, the burden of proving consent lay upon the defendant. This tends to show that his Honour accepted the view that consent is in the nature of a defence to an intentional tort rather than the application of force without consent being a necessary ingredient of the action.<sup>9</sup>

Specifically on the question of “informed consent” his Honour said:

“I have been furnished with a number of decisions mostly from Canada and the United States that seem to say that if consent is not ‘full’, ‘real’, ‘genuine’ or ‘informed’ or similar then seemingly as a matter of law there can be no consent. This is particularly so in relation to informed consent, which predicates the presentation of substantial information by the doctor to the patient . . . But with due respect to the doctrinal argument consent is consent . . . To press further is really to push the matter pleaded in battery to an issue that should be debated within the concept of negligence . . . I would observe that the appropriate place for [informed consent] is in the context of a count in negligence based upon alleged failures to warn or inform.”<sup>10</sup>

This seems to be a categorical rejection of the informed consent question as an issue in battery. His Honour was also clearly of the opinion that inadequate advice or failure to warn might possibly support an action in negligence. This issue was the subject of his Honour’s interlocutory judgment of 23 July 1980. His Honour said:

“The question to be determined is whether there is any evidence upon which the jury can find there was a breach of duty to warn and inform [at all] or to warn and inform in certain terms. The two questions are really aspects of the same general duty, a duty to take reasonable care to avoid a foreseeable risk of injury, to be determined according to a standard of practice — that of the ordinary skilled and competent practitioner in the specialised field of psychiatry”

and later,

“the defendant submits that the plaintiff uses the allegation of . . . lack of informed consent in reality to challenge the question as to

8 Unreported interlocutory judgment delivered 23 June 1980 p2.

9 Contra — see *Latter v Braddell* (1881) 50 LJQB 448.

10 Unreported interlocutory judgment delivered 26 June 1980 p7.

whether there is a breach of duty to take reasonable care by failing to inform or warn . . . What duty, if any, did there lie upon Dr Herron to warn or inform his patients of risks to which they might have been exposed by treatment?"<sup>11</sup>

Fisher J then briefly discussed the landmark medical negligence case of *Bolam v Friern Hospital Management Committee*.<sup>12</sup> This case, his Honour suggested, raised two clear issues. First, whether not warning or informing rendered the defendant doctor guilty of a breach of duty in falling below the standard recognised as proper in his profession or specialty. Secondly, the causation question of whether the plaintiff could show that he would have refused the treatment if apprised of the risks. After reviewing the evidence his Honour held that there had been no evidence adduced by Hart to be put to the jury as to whether there was a standard of practice, and if there was whether the conduct of the defendant fell short of it. In the light of the evidence before him his Honour found there was no evidence fit for the jury to consider on the causation question either.

In a parting shot his Honour similarly declined to follow American and Canadian cases whereby a failure to obtain any or an adequate consent, as a matter of law, grounded an action in negligence. A breach of duty, in his Honour's view, was always a question of fact for the jury.<sup>13</sup>

The outcome was then that the jury never deliberated upon whether there had been a breach of duty related to failure to warn or advise. Fisher J was of the opinion that in an appropriate case a tribunal of fact could find negligence on such a basis. But to do so there would have to be evidence of a relevant standard of behaviour in the medical profession and evidence that the actions of the defendant were in breach of that standard.<sup>14</sup> In the instant case there was no suitable evidence before the jury from which they could assess those questions. Had the course of the cases for plaintiff and defendant been known in advance doubtless that kind of evidence would have been led by the parties.

It is interesting to note that although as a result of the interlocutory judgments both the negligence and trespass manifestations of the "informed consent" doctrine were withheld from the jury, the jury by majority found in favour of the plaintiff on the issues of negligence, assault and false imprisonment. The verdict was for a total of \$60,000 including aggravated damages for assault and false imprisonment of \$24,000. Costs would no doubt have amounted to several times the verdict.

## (ii) *D v S*<sup>15</sup>

In 1981 *D v S* was decided in the Supreme Court of South Australia by Matheson J. The plaintiff attended the defendant surgeon complaining of neck and back pain associated with enlarged and painful breasts. She had undergone at least two previous gynaecological operations.

11 *Supra* n 10 at 15.

12 *Supra* n 1.

13 *Supra* n 11 at 18.

14 This is subject to the "reserve power" of the courts to find that a prevailing and accepted standard is itself negligent, referred to *infra* n 46.

15 *D v S* (1981) 93 LSJS 405. The names of the plaintiff and defendant were ordered not to be disclosed pursuant to s69 Evidence Act 1929 (SA).

During a consultation in November 1976 the defendant told her that he could reduce the size and weight of her bust by the operation of "reduction mammoplasty", thus relieving the headache and neck pain she had been experiencing. She particularly asked him about the scarring that would be left. In reply he drew a diagram showing that there would be a "V" shaped incision under each nipple, the nipple being at the apex. In addition he said there would be a faint hairline scar on each breast which would fade with the passage of time.

She gave evidence, which his Honour accepted, that she was reluctant to have the procedure but that the defendant's tone was reassuring and confident of a good result. She decided to have the operation which was done soon after.

On recovery from the anaesthetic the plaintiff was shocked by the post operative state of her breast. She became quite distressed and showed hysterical symptoms.

The cosmetic effect of the operation was not good. One nipple was larger than the other, the scarring was obvious, the nipples were misaligned and the breasts of unequal size. The psychological effect of her perception of the result was severe. A corrective operation by a plastic surgeon improved the effect somewhat. The trial judge who saw the final result described the scars as still "very prominent and red and . . . grossly disfiguring".<sup>16</sup>

She commenced an action against her surgeon and he admitted liability for the costs associated with the corrective operation but no more.

The action was pleaded in contract, trespass and negligence.<sup>17</sup> His Honour specifically found that no information was withheld from the plaintiff by the defendant in bad faith,<sup>18</sup> although elsewhere in the report his Honour stated that he was not impressed by the defendant as a witness<sup>19</sup> and conversely that he was impressed by the plaintiff as reliable and candid.<sup>20</sup> In the light of the finding of fact that no information was withheld in bad faith it cannot be that the plaintiff's consent was vitiated by fraud.<sup>21</sup> However, his Honour found for the plaintiff both on the trespass count and on the negligence count:

"In my opinion the defendant's negligence extended further than performing the operation unskilfully . . . I think the defendant should have told the plaintiff that there would be incisions around the circumference of the areolae, that the incisions would require stitching, that there could be a loss of sensation in the nipples, that there would be some permanent scars . . . I find that the defendant told her none of these things and that his failure was a breach of duty . . . I am satisfied that if she had been told all of these things she would not have consented to the operation, and

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16 Ibid 416.

17 Ibid 407-408.

18 Ibid 408.

19 Ibid 411.

20 Ibid.

21 The authorities relating to consent obtained by fraud are discussed in *Papadimitropoulos v R* (1956) 98 CLR 249 by the High Court. Although this is a criminal case some idea of the relationship between fraud and consent can be gleaned from it, but it should be applied to civil cases with care.

moreover in all the circumstances her consent was not a true consent. It was not an informed consent".<sup>22</sup>

(a) *Chatterton v Gerson*<sup>23</sup> Applied?

Matheson J's finding for the plaintiff on the trespass issue is interesting in the light of the fact that a recently decided English case, *Chatterton v Gerson*, was cited to his Honour and indeed referred to by him in his judgment.

*Chatterton*, a decision of Bristow J of the Queen's Bench Division, appeared to decisively scotch the informed consent question as an issue in trespass. Its facts were that a woman in severe pain underwent a procedure called intrathecal block. The block consisted of phenol being injected close to a nerve for the purpose of destroying the nerve's pain conducting ability.<sup>24</sup> This was only partly effective but left her with other disabilities. Miss Chatterton sued in both trespass and negligence but failed on both counts. When discussing the trespass aspect his Honour specifically disapproved of the doctrine of "informed consent":

"Once a patient is informed in broad terms of the nature of the procedure which is intended and gives her consent, that consent is real and the cause of action on which to base a claim for failure to go into risks and implications is negligence, not trespass . . . In my judgment it would be very much against the interests of justice if actions which are really based on a failure by the doctor to perform his duty adequately to inform were pleaded in trespass."<sup>25</sup>

Matheson J specifically cited these passages with approval in his judgment<sup>26</sup> and yet went on to hold that an action in trespass had been established. In a passage which may be interpreted as distinguishing *Chatterton's* case his Honour said "This is not a case like . . . *Chatterton v Gerson* where the plaintiff was suffering from excruciating pain."<sup>27</sup> He appeared to take the view that the requirements of consent were different for therapeutic procedures as compared with the more or less cosmetic ones. With respect it is difficult to see that this can be correct. It is clear that a therapeutic operation particularly if urgent or lifesaving may invoke the defence of necessity where the patient's consent cannot be obtained, but there was no evidence of that factor in either *Chatterton* or *D v S*.

No doubt on the basis of the now well established medical negligence case of *Bolam v Friern*<sup>28</sup> and also *Smith v Auckland Hospital Board*<sup>29</sup> it is possible that personal factors relating to the plaintiff in the light of all of the surrounding circumstances can be germane to deciding whether the doctor is guilty of a breach of duty in negligence. This would apply as much to provision of information, or lack of it, as to any other matter

22 Supra n 15 at 419.

23 *Chatterton v Gerson* [1981] 1 All ER 257. A discussion of this case appears in the article Deutsch, "Medical Negligence Reviewed" (1983) 57 ALJ 674.

24 Interestingly it was phenol which caused two patients to be accidentally paralysed in *Roe v Minister for Health* [1954] 2 QB 68.

25 Supra n 23 at 265.

26 Supra n 15 at 418-419.

27 Ibid 419.

28 Supra n 1.

29 *Smith v Auckland Hospital Board* [1965] NZLR 191 (NZ Court of Appeal). This case is also an interesting example of a misapplication of the *Hedley Byrne* principle.

where professional skill and competence are called for. It may be that in dealing with the negligence and trespass aspects in quick succession or simultaneously his Honour has not separated the issues relevant to negligence on the one hand in his own mind from those applicable to trespass on the other. In the final result it is not easy to understand how it can be said that the plaintiff did not understand that she was to have an operation on her breasts and that she had not consented to that operation. That she did not fully understand the implications of it is another question. But on the basis of *Chatterton's* case which his Honour accepted as correct an inadequate briefing would not be sufficient to destroy the effectiveness of the apparent consent given by the plaintiff.

It might also be suggested that *D v S* can be distinguished on the basis that the plaintiff made known to her doctor her fears and anxieties about the operation and specifically canvassed with him the question of the final cosmetic effect, particularly with respect to scarring. She received reassuring answers from him and he made statements about these matters which turned out to be factually incorrect,<sup>30</sup> although it should be stated here again that his Honour made no finding of fraud. It is submitted that there was material before his Honour which may well have justified a finding that the defendant knowingly or recklessly misled the plaintiff into consenting to the surgery. His Honour twice mentioned that the plaintiff was led to believe that the operation was a simple and uncomplicated one<sup>31</sup> and that she believed that a plastic surgeon would at least be present.<sup>32</sup>

Thus the lack of a finding of fraudulent withholding of information or fraudulent misrepresentation has cut off a neat way of distinguishing *D v S* from *Chatterton*, and incidentally from *F v R* and *Hart v Herron*, the two other Australian cases, not to mention *Papadimitropoulos*.<sup>33</sup>

One is left with the pivotal statement of his Honour already quoted, "I am satisfied . . . that in all the circumstances her consent was not a true consent. It was not an informed consent".<sup>34</sup> If by this it is meant that the consent was not "true" because it was not "informed", then *D v S* must be seen as contrary to the orthodox understanding of consent and *Chatterton's* case in particular because an uninformed consent is still an effective consent, though a failure to discuss risks and alternatives may well be a breach of duty in negligence. On the other hand the statement might mean that the consent was both uninformed and for some other reason ineffective, such as the procedure being beyond the scope of the consent given or invalidated because of duress. Alternatively, it might be invalid because of an implicit finding not stated in so many words, that there were serious misapprehensions in the plaintiff's mind planted or encouraged by the defendant that went to the essence of the proposed operation rather than to incidental qualities of it. In such a case it may

30 They were called "false representations" in the pleadings: supra n 15 at 408.

31 Supra n 15 at 410, 411.

32 Supra n 15 at 410. Whether the plastic surgeon was said to be going to perform the operation is not made clear.

33 *F v R* (1983) 106 LSJS 136; (1983) 33 SASR 189 Full Court of Supreme Court of South Australia, on appeal from Mohr J (1982) 100 LSJS 51; (1982) 29 SASR 327 sub nom *P v R*; *Papadimitropoulos*, supra n 21.

34 Supra n 15 at 419.

still be possible to fit *D v S* in comfortably with other cases.<sup>35</sup> There is unfortunately no indication from the report as to how the effectiveness of the patient's consent was destroyed other than due to lack of information.

If it is accepted that his Honour's application of the law of battery to the case is open to question this is far from saying that the case was wrongly decided in the final result.<sup>36</sup> His Honour specifically found for the plaintiff on the negligence count. In doing so, it is respectfully submitted he carefully assessed the evidence and correctly applied the law.

### (b) Causation

One of the vital barriers that a plaintiff in a medical negligence case, based on failure to warn, must surmount is to establish affirmatively, as one of the elements of the case, that if there has been adequate warning or advice the plaintiff would not have undergone the operation or treatment. If this factor is not established the plaintiff has probably failed to show that the damage was caused by the breach of duty.<sup>37</sup> With this factor in mind his Honour exhaustively examined the plaintiff's attitude to her own body and believed that if properly advised by the defendant of the risks and possible consequences of the operation she would have declined to have it.<sup>38</sup> This was one of the grounds upon which Miss Chatterton's case foundered. Bristow J pointedly remarked on it in the closing sentences of his judgment.<sup>39</sup> It is plain that both judges endorse what might be called the "subjective" test of causation. That is, the question is whether or not the actual plaintiff would have proceeded if adequately advised rather than what a hypothetical "reasonable man" would have done.<sup>40</sup>

### (iii) *F v R*<sup>41</sup>

This case can be contrasted with *D v S* and *Hart* on the grounds that "informed consent" was in issue purely insofar as it was relevant to

35 The suggestion that the doctor-patient relationship is fiduciary and the associated question of the effect of undue influence on consent argued interestingly but not very convincingly by Bromberger, "Patient Participation in Medical Decision Making" (1983) 6 UNSWLJ 1 is not pursued here.

36 In fact the case came before his Honour initially on the basis of assessment of damages only. A limited defence was filed after the hearing commenced but liability for the poor cosmetic result of the operation appears to have been admitted.

37 For an excellent example of this in the medical sphere see *Barnett v Chelsea and Kensington Hospital Management Committee* [1968] All ER 1068. This was a case of a casualty doctor refusing to see a patient. The patient subsequently died. It was established that the death was caused by arsenical poisoning and that death would probably have ensued even if the deceased were examined. Thus the breach of duty was too remote from the damage.

38 So much is nowhere stated per se in the report but is clearly implicit from the plaintiff's statement to this effect and his Honour's attitude to her evidence as already discussed. See for example his assessment and her statement: supra n 15 at 411.

39 *Chatterton v Gerson* [1981] 1 All ER 257, 267 where his Honour says "I would not have been satisfied that if properly informed Miss Chatterton would have chosen not to have it [the operation]".

40 This is also the view of Mr Justice Clarke of the Supreme Court of NSW in an extrajudicial statement in Clarke, *Professional Negligence - Doctors and Hospitals, The Solicitor's Role* (1983). This is an excellent treatment of a number of matters relating to medical negligence. Contra see *Reibl v Hughes* [1981] 118 DLR 3d 1, 16 (Supreme Court of Canada reversing the Ontario Court of Appeal on this point).

41 Supra n 33.

negligence. The intentional torts were not pleaded.<sup>42</sup> Shortly stated the facts were that the plaintiff attended the defendant who was a gynaecological surgeon. She was undergoing her third pregnancy and sought advice on sterilisation as a method of preventing her having further pregnancies. The defendant agreed to perform the sterilisation at the same time as the plaintiff was confined for the delivery of the child by caesarian section. The operation was performed, but about two years later the plaintiff again found herself pregnant. It seems that the sterilisation operation of tying the fallopian tubes had spontaneously reversed by a process known as recanalisation. At the trial before Mohr J sitting without a jury, the plaintiff's case had failed on an allegation of battery for lack of informed consent but she had succeeded in negligence based on a failure to warn or advise. The warning which his Honour found should have been given was an assessment of the possibility or likelihood of spontaneous reversal. The plaintiff gave evidence, as did her husband, that if enlightened as to the possibility of recanalisation they would have chosen a more certain form of sterilisation.

The Full Court accepted that the defendant had made a statement to the plaintiff at the time of the consultation to the effect that "I will cut and tie your tubes. I consider it the best method of preventing further pregnancies".<sup>43</sup> Both Mohr J and the Full Court limited their finding of fact about preoperative conversations to this statement and to the husband having raised the possibility of his also having a vasectomy at a joint consultation with the defendant. He was told that this would be unnecessary and he pursued the matter no further.

There were thus two questions for the Full Court. First, whether the failure of the defendant to warn of the chances of spontaneous reversal amounted to a breach of duty. Second, if so, would the damage of a further pregnancy have occurred if a proper warning had been given.

The three judges constituting the Full Court (King CJ, Legoe and Bolen JJ) paid significant attention to the nature of the doctor's duty to a patient including how the content and limits of the doctor's duty is ascertained. As King CJ put it:

"The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment . . . The standard of care required of the appellant was that of an ordinarily careful and competent specialist in gynaecology. The application of these principles to the disclosure of information by a medical practitioner to his patient presents special difficulties".<sup>44</sup>

There was evidence before the court that the worldwide failure rate for tubal ligation operations was between 1 in 100 and 1 in 200. The defendant surgeon's evidence was that she had carried out 600 sterilisations without a single failure.<sup>45</sup> There was also medical evidence

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42 The trespass issue was pleaded at the trial but the plaintiff lost on this point. It was not reargued in the appeal.

43 *Supra* n 33 at 137 per King CJ.

44 *Supra* n 33 at 137.

45 The term failure is frequently used by their Honours. However it might not be strictly correct to say that the subsequent spontaneous reversal of an efficiently done operation meant that the procedure as performed was a "failure".

that tubal ligation was the appropriate form of sterilisation for the plaintiff and that more radical methods such as hysterectomy, although not subject to spontaneous reversal, were not indicated. In the light of this evidence all members of the court seem to have acknowledged that the ultimate question was really whether it was a breach of duty for the surgeon to fail to volunteer information as to the possibility of recanalisation which she knew of and believed to be small. Unanimously they held it was not. On three independent, though at many points similar, lines of argument all three judges disagreed with the trial judge and allowed the appeal.

There was general agreement among their Honours that adherence to the usual practices of the medical profession is strong evidence negating negligence but is not conclusive on the point.<sup>46</sup>

### (3) CAN THE CASES BE RECONCILED?

At the simplest level *D v S* is the odd man out in that it was a victory for the plaintiff patient on "informed consent", both in battery and in negligence. But as all of these cases turn on the legal effect of discussions between doctors and patients before surgical operations or other treatment regimes can they not be reconciled on a closer analysis?

#### (a) *The Battery Aspect*

This issue really comes down to when an apparent consent is effective consent. As Fleming states a misapprehension "[R]elating to a wholly collateral matter which operates merely as an inducement, does not destroy the reality of consent".<sup>47</sup> The difficulty is discerning whether the lack of information, advice or warning, or in some cases, misinformation, is "wholly collateral".

In *Hart's* case Fisher J does not really attempt to define consent in abstract terms but is content to be able to know it when he sees it. He was confident that a failure to supply information about a particular treatment did not destroy the reality of consent when the patient assented to it explicitly or implicitly. This view was shared by Bristow J in *Chatterton*. Both of them asserted that "informed consent" was an attempt to turn a negligence action into a battery case. In *F v R* the question got short shrift from Mohr J at the trial and, as already noted, was not reargued on appeal.

With some difficulty even *D v S* can be distinguished on the basis that, to the patient at least, the matters discussed pre-operatively were not, in Fleming's words, "wholly collateral" with the result that there was no true consent. This view might be strengthened by the clear evidence before the court that the end result cosmetically speaking was of prime importance to the patient. The two difficulties with this are, first, the problem discussed supra, namely, gleaning from the report his Honour's exact reasoning in finding for the plaintiff in battery; and second, if *D v S* is to be distinguished from *F v R*, the fact that in *F v R*, the

<sup>46</sup> Eg supra n 33. Eg King CJ at 141, and Bolen J at 148. This is a useful corrective to *Hart*, *Chatterton* and *D v S* where all of the trial judges endorse the pure medical standard without specific reservation. The approach of the Full Court in *F v R* is consistent with the High Court in *Mercer v Commissioner for Road Transport etc* (1936) 56 CLR 550 and Reynolds JA in *Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542, 562f.

<sup>47</sup> Fleming, *The Law of Torts* (6th edn 1983) 74.

importance of the plaintiff wife having no further children was made plain to the defendant. The plaintiff husband even emphasised the point by suggesting that he also be sterilized.

The end result is not very satisfactory for it is that *D v S* can be seen as consistent with *Hart*, *F v R* and *Chatterton* only if Matheson J's decision can be explained along lines that his Honour does not state.

*(b) The Negligence Aspect*

On one central point of law the cases do not need to be reconciled, they are unanimous. That point is that a medical practitioner may have a duty in the tort of negligence to warn, inform or advise a patient about the risks, consequences and implications of proposed medical or surgical procedures.

Again *D v S* is exceptional because it is the only case considered where the plaintiff actually succeeded on this ground. This only means however that there the plaintiff succeeded as a matter of evidence, whereas the other plaintiffs lost on the same basis. No doubt the active questioning of her doctor by the patient in *D v S* strengthened her case. This is because the doctor's knowledge of the patient's needs can set the scene for the appropriate standard of care, which in this case, the defendant seems to have admitted having breached.<sup>48</sup>

So far as negligent failure to warn was concerned, *Hart's* case failed for lack of evidence at the threshold and the issue was never put to the jury. Neither the summing-up to the jury nor the interlocutory judgments discuss doctor/patient discussions in sufficient detail to discern whether it would be treated as inadequate answers to specific questions or a failure to volunteer facts.

The only appellate case here reviewed is *F v R* where the defendant prevailed because the plaintiff failed to establish a breach of duty to warn and advise on the facts. The case proceeds on an orthodox understanding of medical negligence with *Bolam's* case being cited with approval by all members of the bench. In essence the decision of Mohr J was reversed because his Honour was held to have set the standard of care with respect to warning and informing too high.<sup>49</sup> The likelihood of spontaneous reversal was held to be too small in the circumstances to find a breach of duty in not volunteering an opinion about recanalisation.<sup>50</sup>

All of their Honours declined to consider the causation question of whether the plaintiff would have gone ahead with that form of sterilization had the suggested explanation been given.

**(4) CONCLUSION**

It is submitted that a number of tentative conclusions can be drawn from these three relatively recent Australian cases.

First, the American doctrine of informed consent as grounding an action in battery has probably not taken root.<sup>51</sup> *D v S* is the only case

48 See *Bolam v Friern* supra n 1, *Smith v Auckland Hospital Board* supra n 29 and King CJ in *F v R* supra n 33 at 139, 140.

49 Supra n 33 per King CJ at 143; Legoe J at 146; cf Bollen J at 154 where he says that it is a case of no duty of care arising because of no foreseeability of harm.

50 All judges considered it a case of a failure to volunteer information.

51 Clarke supra n 40 suggests that it is in eclipse even in America.

to suggest otherwise and on analysis it can either be explained as decided on other grounds or be seen as inconsistent with Australian law on this point.

Second, the reluctance to accept informed consent has not been sheeted home to any previously decided case but depends on a treatment of the tort of battery from first principles.

Third, the courts have been much more willing to entertain the notion that failure to warn, advise or inform may constitute a breach of duty for the purposes of the tort of negligence. Where a breach of duty on these grounds is alleged it seems that it will be seen as one aspect of a doctor's overall responsibility to protect a patient from foreseeable harm. Moreover, whether or not a breach of duty is established in any individual case will be decided in the light of all of the surrounding circumstances of the case. To put it another way, there is no independent cause of action of failure to inform. It is but one aspect of the general duty of care.

Finally, one of the important circumstances to be considered will be the practice of the ordinarily skilful member of the profession or branch of it from which a defendant holds himself out. However in appropriate cases there is a "reserve power" in the courts to find that any practice or standard of conduct in the profession is itself negligent, though semble, this power will be used only infrequently and in extreme cases.

So while there probably is no doctrine of informed consent as grounding an action in battery, failure to inform patients adequately can lead to an action in negligence at the suit of patients against their medical advisors. But in a negligence action the patient will bear the burden of proof of all elements of the case including establishing that if fully informed they would not have proceeded with the operation.