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THE IMPACT OF THE CONSENT TO MEDICAL AND DENTAL PROCEDURES ACT 1985 (SA) ON COMMON LAW PRINCIPLES OF INFORMED CONSENT IN SOUTH AUSTRALIA

1. INTRODUCTION

The medical-legal issue of informed consent to treatment has been the subject of consideration in Australia by courts,[1] legislatures,[2] law reform bodies,[3] government commissions[4] and scholars.[5] So far, the most important developments have taken place in South Australia, where the issue of informed consent has been the subject of several Supreme Court decisions, a report by a special government working party, academic articles, and at least two pieces of legislation.

The specific focus of this paper is, first, to describe briefly the law of informed consent as it has been developed by the courts in South Australia;[6] second, to look closely at the Consent to Medical and Dental Procedures Act 1985 (SA); and third, to discuss some general issues relating to informed consent.

2. THE COMMON LAW

The development of informed consent as an ethical and legal principle has been fully discussed elsewhere. Briefly, it is based on the legal, moral and ethical notion of respect for personal autonomy. One's personal integrity may not be violated without one's consent. This principle underlies much of the criminal law, which prohibits and punishes threats and/or injury to persons, and the civil claim of trespass to the person (assault/ battery).

In the specific context of medical care, this principle ordinarily means that, for medical treatment to be lawful, the patient must have agreed to

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1 *D* v *S* (1981) 93 LSJS 405; *F* v *R* (1983) 33 SASR 189; *Hart* v *Herron* [1984] Aust Torts Reports 80-201; *Battersby* v *Tottman* (1985) 37 SASR 524; *Gover* v *Perriam* (1985) 39 SASR 543.

2 Consent to Medical and Dental Procedures Act 1985 (SA), Mental Health Amendment Act 1985 (SA), Mental Health Act 1986 (Vic).

3 Law Reform Commission of Victoria, *Informed Consent to Medical Treatment* (Discussion Paper No 7, 1987).

4 South Australia, Health Commission, *Report of the Working Party on Consent to Treatment* (1983).

5 Law Reform Commission of Victoria, *Informed Consent, Symposia* (1987); Bromburger, 'Patient Participation in Medical Decision-Making: Are the Courts the Answer?' (1983) 6 UNSWLJ 1; Smith, 'Some Recent Cases on Informed Consent' (1984) 9 Adel LR 413; Iles, 'Curial Inconsistencies in the Doctor's Duty of Care' (1987) 11 Adel LR 88.

6 The discussion in this comment does not address the more difficult questions of consent in an experimental or research situation or proxy consent on behalf of persons who lack capacity. The principles discussed here refer specifically to consent requirements for therapeutic medical procedures on persons with capacity to consent.

it. Stated in this simple, general fashion, most persons — including most lawyers and doctors — would agree with the principle. A physican treating a patient who has not given any consent at all commits battery. An example of this is *Murray v McMurchy*[7] where a physician was liable for damages for battery when he sterilised a woman who had agreed only to a Caesarian delivery.

A more complex situation arises where a patient agrees to a proposed treatment or procedure (so that there is no battery) but claims that the information which led to the agreement was inadequate. Such a claim lies in negligence and is based on the argument that, by failing to disclose certain information, the physician has breached a duty of care to the patient. This claim of lack of informed consent does not deny the existence of consent; such a claim challenges the adequacy of the information on which the patient's agreement was based.

As the common law has developed in South Australia, battery has usually been applied in only the most appalling cases, where it is said that there is no consent at all to a treatment of the kind that was actually given.[8] In the three leading South Australian cases, (*F v R*, *Battersby v Tottman*, *Gover v Perriam*), the claim for damages based on lack of informed consent was raised in negligence.[9] In deciding these cases, the South Australian Supreme Court has developed a clear and distinctive approach to the legal standard for informed consent to medical care.

Basing an informed consent claim in negligence may seem confusing for another reason. In the medical malpractice area, negligence usually means that diagnosis, advice or treatment was carried out carelessly or improperly or without adequate technical skill, and the injury which resulted was avoidable with proper diagnosis, advice or correctly performed treatment. In the cases under consideration, the injury arises *not* from an inadequately performed medical procedure but from a risk inherent in a treatment adequately carried out, a risk known to the doctor but *not* disclosed to the patient. Harm is caused by the inadequate information because, had adequate information been given, the patient would not have agreed to the treatment which resulted in the injury. For example, a laminectomy, even when properly performed, carries with it a 1-2% risk of damage to the spinal cord leading to paralysis.[10] A patient who agrees

7 [1949] 2 DLR 442.

8 Robertson, 'Informed Consent to Medical Treatment' (1981) 97 LQR 102, n 10 at 124; *Murray* v *McMurchy* ibid, *Chatterton* v *Gerson* [1981] QB 432, 442-443. There are significant practical advantages for a plaintiff to raise a claim in trespass based on battery; Somerville, 'Informed Consent: An Introductory Overview' in *Symposia*, above n 5 at 8; Smith, above n 5 at 413-414. Some discussion has been directed at reviving this theory of compensation: Feng, 'Failure of Medical Advice: Trespass or Negligence' (1987) 7 Legal Studies 149; Teff, 'Consent to Medical Procedures: Paternalism, Self-determination or Therapeutic Alliance' (1985) 101 LQR 432. This was the theory argued in *D* v *S*, below n 9, though negligence was alleged as well.

9 There is an earlier South Australian case *D* v *S* (1981) 92 LSJS 405 in which Matheson J concluded that the information given was not adequate and that, had she been told, the patient would not have consented; therefore, there was no informed consent. However, the case was decided largely on the basis of truly appalling incompetence in treatment with very serious resulting damage, and the consent issue was only very briefly discussed.

10 *Sidaway* v *Bethlem Royal Hospital* [1985] 2 WLR 480, 485.

to this procedure without being told of this risk and is paralysed may claim damages for negligence, if the patient also shows that the treatment would have been refused had adequate information been given.

Thus, a claim in negligence requires the plaintiff to prove (1) that the doctor's general duty of care includes an obligation to inform of certain risks; (2) a breach of that duty by not informing of those risks; and (3) harm caused by that breach because injury resulted from a procedure or treatment the patient would not have agreed to had the true risk been disclosed. The central question is whether 'the doctor, in the disclosure or lack of disclosure which has occurred, acted reasonably in the exercise of professional skill and judgment'.[11] The real difficulty arises in determining the information which must be given (and, correlatively, the information which may be withheld) and the factors which must be considered in answering these questions. Variables include the age of the patient, the mental, emotional and physical condition of the patient, the physician's judgment as to the treatment needs of the patient, the patient's questions or denial of desire for information, the nature of the risk, the seriousness of harm and its likelihood of occurrence, and the nature of the proposed medical procedure.

In Australia it has been left largely to the courts, in the context of a lawsuit by a patient against a doctor, to identify the significant factors and how they should be weighed.

To determine if the standard of care owed by the medical practitioner includes an obligation to disclose the information in issue, a court relies on expert evidence as to the general practice of reasonable or prudent doctors regarding disclosure. However, the South Australian Supreme Court has frequently stated that such testimony is not conclusive.[12] If the court finds that the accepted medical practice is below the appropriate legal standard, then a doctor's actions could be held to be a breach of legal duty to inform and hence actionable, even though the physician's conduct conformed to an accepted medical practice.

Risks which must be disclosed according to the South Australian Supreme Court in *F v R* include:

> 'not only . . . real risks of misfortune inherent in the treatment but also any real risk that the treatment, especially if it involves major surgery, may prove ineffective'.
>
> 'a small risk of great harm might call for disclosure, though a greater risk of slight harm might not'.[13]

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11 *F* v *R*, above n 1 at 191.

12 By King CJ in *F* v *R*, ibid 193, 194, 196, and Bollen J 200-205; by Zelling J in *Battersby*, above n 1 at 537 and by Cox J in *Gover*, above n 1 at 551. This is in contrast to the UK position which accepts that 'the criterion of the duty of care is whether the doctor has acted in accordance with a practice accepted as proper by a body of responsible and skilled medical opinion' by Lord Diplock in *Sidaway*, above n 10 at 498. This is the House of Lords interpretation of the *Bolam* test. It is clear however that courts in South Australia will, quite properly, follow their own precedents in preference to the House of Lords; see *Gover*, above n 1 at 352. In any event it appears that *Sidaway* is being narrowed and distinguished; Brazier, 'Patient Autonomy and Consent to Treatment: The Role of the Law?' (1987) 7 Legal Studies 169, 182; Mason, 'Informed Consent: An Overview' in *Symposia*, above n 5 at 134-135.

13 *F* v *R*, above n 1 at 191-192.

Other circumstances which affect what must be disclosed include:

(1) 'matters which might influence the decisions of a reasonable person in the situation of the patient'.
(2) The 'nature of the treatment' including 'existence of reasonably available alternative methods of treatment'.
(3) The expressed or apparent desire for information. A doctor must give a truthful answer to an express request for information.
(4) The 'temperament and health of the patient', including whether the 'patient's health, physical or mental, might be seriously harmed by the information', and the capacity of the patient to 'make the information a basis for rational decision'.[14]
(5) Other general surrounding circumstances.[15]

So far, there has been no case in South Australia which has found that a doctor's duty of care required disclosure which would not ordinarily be disclosed as part of the standard medical practice.[16] However, from the tone of remarks in at least two judgments,[17] there is some dissatisfaction with medical practice and the courts may be readier in the future to impose a legal standard higher than the prevailing medical practice.

The second issue is proof of a breach. Having decided what information should be given to a patient, the court must then resolve any factual conflicts by hearing testimony from patient, doctor, and other witnesses, and reviewing any written materials such as notes of treatment, and signed consent forms. Courts, however, give little weight to uninformative, generally worded consent forms and have been very critical of inadequate medical record keeping.[18]

The third major legal requirement for a plaintiff to win a judgment on informed consent grounds is to show causation. In *Gover*, Cox J decided that the plaintiff must show that, had the plaintiff known of the undisclosed risk, she would have refused the treatment given.[19] The court asks: 'What would this individual patient have actually (subjectively)

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14 Ibid 192-193.

15 These criteria contrast strongly with the position expressed by members of the House of Lords in *Sidaway*, which adopts a much less rigiorous standard, essentially treating disclosure as a matter for the clinical judgement of the physician. See Iles, above n 5. However, their Lordships did not fully agree on a verbal formulation for this principle, and there was a strong judgment by Lord Scarman rejecting it. The Supreme Court will almost certainly continue to follow its own carefully developed analysis in this area.

16 In *Gover*, above n 1, the court found that a physician's failure to disclose was a breach of duty. The physician did not warn because he claimed the complication was unforseeable, at 562-563. The medical evidence, however, established that such a risk was well known, though the evidence was divided as to whether a warning was a usual practice, 563.

17 By King CJ in *F* v *R*, above n 1 at 196 and Zelling J in *Battersby* v *Tottman*, above n 1. Brazier, above n 12, sees a similar development in the UK.

18 *Gover*, above n 1 at 554, 558; in *D* v *S*, above n 9, the doctor's testimony was simply not believed by the court, and there were no adequate notes or other records.

19 In choosing this interpretation of the causation requirement, Cox J recognised that there was no direct Australian authority on the point and that an appeal court might choose to apply a different rule on policy grounds. The alternative test for causation adopted in the United States and Canada is an objective

decided, had the undisclosed information been given?' This is the so-called subjective test. As Cox J recognised, it imposes a 'considerable practical barrier' for a plaintiff.[20]

Thus, if a plaintiff in South Australia sues on the basis that there was no informed consent to treatment, the plaintiff will recover damages only if the plaintiff shows, on the balance of probabilities, that the doctor's duty of care included an obligation to disclose certain information and that the doctor breached that legal duty to disclose and that the plaintiff, if aware of the undisclosed information, would have refused the treatment actually given.

This is a very heavy burden. No plaintiff in a reported case in South Australia has recovered on a claim based solely on failure to obtain informed consent.[21] Only one plaintiff (in *Gover*) was able to establish a breach of duty to disclose, but causation was not established in that case.

3. CONSENT TO MEDICAL AND DENTAL PROCEDURES ACT 1985 (SA)

The question which is raised by the Consent to Medical and Dental Procedures Act 1985 (SA) is whether the Act displaces these legal rules which the courts have developed in this area.

Apparently the Act does not purport to address the general matters discussed above. It is designed to clarify the capacity of minors to consent to medical treatment, to set up procedures to follow for treating minors who are not capable of consent and to clarify the capacity of doctors to render treatment in an emergency. As the debate in Parliament shows, there had been some concern about a perceived uncertainty in the common law on these points. The Act resolves these questions clearly and effectively by adopting a careful (though controversial) balance of the relevant interests of the child, the parents, the physician and the general community.

The Act provides that minors of or above the age of 16 have full legal capacity to consent.[22] For minors younger than 16, parental consent is

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19 *Continued*
standard where causation is determined by asking how a hypothetical reasonable patient would have acted had full proper disclosure been given. *Canterbury* v *Spence* 464 F 2d 772, 790-791 (1972); *Reibl* v *Hughes* (1980) 114 DLR (3d) 1, per Laskin CJC 15-17, 35. The subjective test had been applied, without discussion, in the early case of *D* v *S*, above n 9.

20 *Gover*, above n 1 at 566. The court commented:
> 'It must be acknowledged that there are practical difficulties in applying the subjective test in cases of this sort. The court has to reach a decision about a topic to which the patient, in most cases, will not have addressed his mind at the time that matters most. His evidence as to what he would have done is therefore hypothetical and is very likely to be affected, no matter how honest he is, by his own particular experience. The application in this field of the ordinary rule governing liability in negligence is also criticised as raising a considerable practical barrier for would-be plaintiffs. It will often be very difficult to prove affirmatively that a patient would not have taken a risk, say, that the evidence shows that many other people freely take.'

21 See discussion of *D* v *S*, above n 9.

22 s6(1).

effective,[23] or the consent of the minor may be effective if certain circumstances are met.[24] For persons (whether adults or minors) unable to consent in emergency situations, treatment is authorised by 'prescribed circumstances' and consent is deemed to exist when those circumstances exist.[25]

The Act concludes in s8 by providing that consent given or deemed under the Act is 'effective' and that a physician will not incur any civil or criminal liability for a 'reasonably appropriate' procedure, performed 'in good faith and without negligence' with the patient's consent.

The concern of this article is not with the Act's clarification of consent by and on behalf of minors or in emergencies, but rather with a possible general application of s8. On its face s8 appears to go much further than merely providing a fairly obvious legal conclusion to the previous sections of the Act. It provides that:

> '8. (1)Notwithstanding any rule of the common law, but subject to the provisions of any enactment —
> (a) the consent of a person to the carrying out of a medical procedure or dental procedure on him is effective whatever the nature of the procedure provided that the procedure is reasonably appropriate in the circumstances having regard to prevailing medical or dental standards: and
> (b) no criminal or civil liability shall be incurred in respect of the carrying out of a medical procedure or dental procedure on a person with his consent if —
> (i) the procedure is reasonably appropriate in the circumstances having regard to prevailing medical or dental standards; and
> (ii) the procedure is carried out in good faith and without negligence.
>
> (2) In subsection (1) —
> 'consent' of a person means a consent as defined in section 4 given or deemed under this Act or any other Act to be given by a person where —
> (a) the person is of full age and is otherwise capable of giving an effective consent; or
> (b) the consent is deemed to have the same effect as if the person were of full age or were capable of giving an effective consent.'

Consent is defined in s4:

> 'In this Act, unless the contrary intention appears 'consent', in relation to the carrying out of a medical procedure or a dental procedure, means an informed consent given after proper and sufficient explanation of the nature and likely consequences of the procedure.'

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23 s6(4).
24 ss6(2) and 6(3).
25 ss6(5), 6(6) and 7. For a fuller and clearer summary of these aspects of the Act see Bennetts, 'Consent to Treatment: Legal Aspects of the Consent to Medical and Dental Procedures Act 1985' (1987) 11 Adelaide University Continuing Legal Education Law Papers 1.

The meaning of s8 is not at all clear.

(1) Does s8 apply: (a) only to minors and emergencies, or (b) generally to all persons and situations?

(2) If s8 does apply generally does it: (a) merely restate the law of informed consent summarised above, or (b) vary it and replace it with a much less rigorous standard?[26]

The opening phrase of s8 appears to sweep away all common law principles, thus suggesting both general application and a change in the law. However, this phrase, as with all statutory language, must be read in the context of the Act as a whole.

All other sections of the Act refer *only* to treatment of minors or to emergency treatment. Thus, the most reasonable interpretation of this phrase is that it is intended to displace common law principles only with respect to treatment of minors and emergency treatment. This interpretation is strengthened when one realises that, in s3, the Act repeals a former Act which dealt only with the treatment of children. It seems unlikely that Parliament would have tacked a provision with such broad impact onto a specialised Act.

Another part of s8 which bears on the question of its general or narrow scope is s8(2). Sub-section 8(2) defines consent as used in ss(1) to include:

> 'consent as defined in section 4 given or deemed under this Act or any other Act by a person . . . of full age . . . or . . . consent . . . deemed to have the same effect'.

As a matter of grammar this provision is itself ambiguous and/or internally contradictory. The phrase 'given or deemed under this Act' can be read in two different ways. Under one reading, s8 applies to 'consent . . . as defined by section 4 . . . given . . . by a person . . . of full age . . . and capab[ility] of giving effective consent'. This reading broadens the consequences of consent described in ss8(1) to all adult persons and goes well beyond the scope of the rest of the Act which provides only for minors and emergencies. A second reading is to treat the phrase 'under this Act' as referring both to consent given and to consent deemed, thus reading ss8(2) as 'consent given [under this Act] or deemed under this Act'. This reading limits the effect of ss8(1) to minors and emergencies and is clearly preferable. It is more logical and more consistent with the overall structure, subject and purpose of the Act.

However, if the latter reading is chosen, then the phrase in ss8(2)(a) referring to a 'person of full age' possibly becomes surplusage. This can be avoided by recognising that s8 is also meant to apply to other legislative schemes about consent dealing with adults, such as those mentioned in s5 of the Act. Thus, it is possible to read ss8(2) in a manner consistent with the Act as a whole, applying only to minors and emergencies, and not displacing all common law rules of informed consent.

Given the enormous ambiguity in the meaning of s8, it is appropriate to look at Parliamentary intent and the objects and purposes of the legislation. Extrinsic materials may be examined to determine the mischief which a statute was designed to remedy.

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26 It should be noted that the Law Reform Commission of Victoria in its Discussion Paper, above n 3 at 35, para 74 in a very brief comment treats s8 as having general application.

The legislation was based on the *Report of the Working Party on Consent to Treatment* given in December 1983.[27] This report specifically recommended the need for legislation with regard to consent by minors and in emergency situations.[28] However, the report thoroughly considers and specifically rejects the introduction of any general legislative scheme of informed consent.[29]

A review of the extensive Parliamentary debate on this Bill in both the Legislative Council and the House of Assembly clearly shows that the only mischief the legislation meant to remedy was a perceived uncertainty in the common law about the legal effectiveness of consent by or on behalf of minors and emergency medical treatment. These were the only issues discussed. In the second reading speech it is stated that the Act as a whole 'clarifies the existing common law particularly in relation to consent by minors'.[30] The summary of clauses provided by the Minister merely restates the statutory language in condensed form and does not address the interpretation issues raised.[31]

The debates include a few very brief comments on the existing general common law relating to consent which give no real guidance at all on the relationship of s8 to the existing common law rules:

> 'As far as adult persons, 18 years and above, are concerned, it is accepted that informed consent by a patient to any medical or dental procedures authorises the practitioner to proceed without risk of a subsequent charge of assault. This accepted practice does not affect the liability of a practitioner when negligence or malpractice may be alleged, and such liabilities are reaffirmed in clause 7 of this Bill.[32]

> While the law in respect of informed consent by adults is clear, the ability of minors to consent to medical and dental procedures is uncertain. There is no Statute law concerning this matter in South Australia, and the common law situation is somewhat confused. Accordingly, it is alleged that medical and dental practitioners are uncertain whether the free and informed consent of a responsible minor is sufficient to avoid the possibility of being sued for assault either by the minor or by his or her parents, or whether it is mandatory for the practitioner to obtain the consent of a parent or guardian before undertaking treatment of a minor.'[33]

This statement is ambiguous. It could suggest that Parliament (or at least the opposition member speaking) understood s8 to have general application, but not to change existing law or it could mean that Parliament wished to make the legal effect of the various forms of consent by or on behalf of minors, as defined by the Act, the same as that of adults under the common law.

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27 Above n 4.
28 Ibid 25-26.
29 Ibid 40-44.
30 SA, Parl, *Debates* (1984-1985) vol 2, 1851-1853.
31 Ibid.
32 Section 8 in the Act.
33 Hon D Laidlaw, SA, Parl, *Debates* (1984-1985) vol 3, 2768.

However, if ss8(2) is interpreted as applying generally to all persons there are still questions about its meaning and effect on the common law rules described above.

To understand the full meaning of s8 and to decide if it does change the general common law relating to informed consent by adults in non-emergency situations, one must focus on the words of the Act itself. The interpretation of the definition of consent in s4 which is imported into s8 by ss8(2) becomes crucial. Consent in s4 is defined as 'informed consent given after proper and sufficient explanation of the nature and likely consequences of the procedure'.

It is not clear whether the phrase 'proper and sufficient explanation of the nature and likely consequences of the procedure' is meant to be an exhaustive definition of the term 'informed consent'. If this is so, it could be a significant reduction in the standard developed in *F* v *R*, which required consideration of a number of other factors besides the nature and likely consequences of the procedure.[34] However, this is not the most likely interpretation of the definition as a matter of general statutory interpretation principles, nor is it apparently the intention of the drafters. 'Informed consent' has now become a term of art, and, generally, technical legal terms in legislation will be given their technical meaning. Application of this principle to the definition of consent in the Act would permit a court to interpret the phrase 'informed consent' by reference to the much fuller standard of informed consent developed by the South Australian Supreme Court.[35]

However, even if the definition of consent in the Act is meant to be a comprehensive definition of what is necessary for informed consent exclusive of the common law, the phrases 'proper and sufficient explanation' and 'nature and likely consequences' would themselves have to be interpreted by the courts. Presumably the courts would follow their own definitions or criteria for determining what is a proper and sufficient explanation and include the extensive list from *F* v *R*.[37]

The two exclusions created by ss8(1)(b) also raise problems. The effectiveness of consent and the corresponding 'immunity' from criminal or civil liability created by ss8(1)(a) and 8(1)(b) are removed if the treatment is not 'reasonably appropriate'[37] or if it is 'negligent'.[38]

The simplest interpretation, in the specific context of the Act, is to treat the requirement of a 'reasonably appropriate' procedure as an outer limit

34 See Division 2 of this article.

35 This argument is, of course, weakened somewhat by the phrase 'notwithstanding any rule of the common law'. The phrase is not however dispositive of the argument. The definition in s4 does not itself expressly exclude the common law. Apparently, the SA Health Commission itself is unclear on this point. The Commission's publication *Information for Medical and Dental Practitioners on the new Legislation relating to the Consent to Medical and Dental Procedures Act 1985 and the Mental Health Amendment Act 1985* (1986) treats the definition in s4 as providing a general test of consent but, in listing the information which should be given, includes 'alternative procedures' which is not by the terms of s4 necessary.

36 Summarised above in Division 2 of this article.

37 s8(1)(b)(i).

38 s8(1)(b)(ii).

for the immunity afforded for medical procedures on minors or in emergencies. It seems to be intended that the procedures for obtaining consent in the Act, especially those permitting medical care for minors under 16 whose consent is treated as being legally effective or in opposition to parental views, should only be effective to insulate a doctor from liability if the procedure chosen is a usual one. Presumably this is meant to prevent actual or deemed consent of minors from being effective with respect to experimental or controversial forms of treatment, or to prohibit emergency use of such treatment.

However, if s8 is meant to operate generally, the meaning of this subsection of s8 is most uncertain. It appears that the legislation has leaped from issues of consent to the much broader question of the standard of care in treatment. It is possible that ss8(1)(b)(i) means that the legal standard of care is met if a procedure is reasonably appropriate in light of the prevailing medical and dental standards. This interpretation could mean that the legal standard is set by medical practice, which is a very different rule than that established by the South Australian Supreme Court in developing the common law principles.[39] The best interpretation on this point is that ss8(1)(b)(i) simply restates the view expressed in *F* v *R* that a court will consider evidence of the practice of the profession in determining whether the standard of care required by the law is met but is not bound by such evidence. This view is supported by the statutory language 'having regard to' which requires only that a court consider the information.

The second exclusion created by ss8(1)(b)(ii), that consent is effective if care is not negligent, is also confusing. One possible reading, and the one most likely intended, is to interpret negligence as referring only to a breach of a doctor's duty to use adequate skill and care in diagnosis, advice and actual treatment. Thus, the protection given by s8 against claims based on lack of consent operates only so far as a claim is based on inadequate consent alone. The purpose appears to be to leave a doctor vulnerable to a claim based on legally inadequate diagnosis, advice or treatment, regardless of consent, and to prevent a doctor from claiming that the actual or deemed consent is a defence to an action for bad treatment. Such a provision is, of course, sensible. Legislation on informed consent should not insulate a doctor from legal responsibility for a medical procedure which is negligently performed. However, giving this meaning to the actual text of s8 is difficult because it appears that a technical term in legislation is being used in other than its technical sense. As the previous summary pointed out, in South Australia a claim against a doctor based on inadequate consent is brought in negligence, as a breach of a general duty of care which includes a duty to inform. By providing immunity from claims when consent is adequate, except when the physician is negligent, the section actually has the effect of reimporting a doctor's common law duty to inform. If the common law standard is the same as that under the Act, the section is a tautology. If the common law standard is higher, then the section is self-defeating.

Perhaps the most serious difficulty in s8 is the provision in ss8(1)(a) that consent is 'effective' and in ss8(1)(b) that no liability will arise for a procedure carried out with consent.

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39 See Division 2 of this article.

If ss8(1)(a) means what it says, then ss8(1)(b) doesn't add anything. To articulate the test as to whether consent is effective or ineffective misuses the legal concept of consent. Similarly, to talk about not incurring civil or criminal liability if there is consent misses the point as well.

The confusion arises in part because of the two possible claims which can be raised: battery and negligence.[40] Neither of these legal claims raises any question of effectiveness or ineffectiveness of consent.

If there is no information or substantially wrong information, apparent agreement is not consent at all and a doctor may be guilty of or liable for battery.

If the patient has some information about medical treatment, that patient's agreement may be sufficient consent to protect a doctor from committing a battery. However, there may not be enough information to allow the patient to give informed consent. In that situation a doctor may be liable in negligence for a breach of a duty to inform.

If a physician gives adequate information (either under the common law or as provided in s8, if it is different), a doctor is not liable because no legal duty of care has been breached, not because of some special exemption from liability for one who has breached the law.

Physicians, like the rest of us, are not liable if they act according to legal standards and are subject to liability if they breach legal rules. The problem is making those standards clear and just.

4. GENERAL ISSUES REGARDING INFORMED CONSENT

If s8 was an attempt to loosen the requirements of informed consent, it was almost certainly a response to the view of some medical practitioners that they are somehow being subjected to an unreasonable intrusion of the law into their professional domain. However, as discussed above, the common law standard is clear in many respects and provides a great deal of protection for physicians. In all the reported cases in South Australia, no plaintiff has recovered on a claim resting primarily on informed consent. Statistics from a national survey in the United States suggest that informed consent was raised as an issue in only 3 percent of cases.[41] What upsets doctors, judging from remarks by acquaintances and comments made at a recent Continuing Legal Education Seminar at the University of Adelaide, is the mere fact of being sued and having to defend or justify their conduct, whether or not the plaintiff succeeds in obtaining damages. Somerville describes this as a well-founded fear that the power base of physicians is being altered.[42] (This fear is not, of course, a universal view.)

No provision in any statute is going to give the medical profession complete protection from challenge. Unfortunately, physicians sometimes appear to feel that if a plaintiff loses in the end, the action should never have been brought at all. This reflects a fundamental misunderstanding of the legal world in which all persons including physicians must operate.

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40 Ibid.

41 Kennedy, 'Patient on the Clapham Omnibus' (1984) 47 MLR 454, 468; Law Reform Commission of Victoria, *Informed Consent to Medical Treatment* (Discussion Paper No 7, 1987) 35, n 1.

42 Above n 7.

On the other hand, there is some justice in physicians' complaints because, in a sense, the actions brought against them may well be 'undeserved', because they are in part the result of factors unrelated to the quality of medical care. Especially in the United States, where there is no adequate provision for injury compensation outside workers' compensation or automobile accidents (and even the latter depends on a choice to insure privately), the only way a person can receive any financial assistance to cope with a disabling injury is to sue someone and win.[43] Thus, much of the pressure on the legal system arises not from greedy plaintiffs, or greedier lawyers[44] or incompetent doctors, but is the necessary result of an inadequate social welfare system. Doctors (or hospitals or manufacturers or municipalities) have the ability to spread the cost of compensation through insurance. An individual who has suffered injury through a bad result in a medical procedure had no way of avoiding the injury and no readily available way of insuring against the loss. Unfortunately, in the absence of a system which rationally decides where and how to impose costs of compensation for injuries, people will turn to lawsuits, where the results depend on fault, rather than the need for compensation. This creates pressure to find fault in very marginal cases, in order to provide clearly needed compensation. This is but one of several factors which has led to an increase in claims based on informed consent (as well as on other grounds). Other factors include changes in the community's view of the medical profession and an increased emphasis on participatory rather than authoritarian decision-making generally.

Given that at least some of the factors which affect the likelihood of a physician being sued are societal and beyond a physician's immediate control and that the legal system is probably already providing the doctor with as much protection from liability as the general community will tolerate, what advice can be given to a conscientious physician to limit exposure to lawsuits on informed consent grounds?

Obviously one way for a doctor to achieve total protection from all lawsuits on any grounds is simply never to have a bad result!! Equally obviously this is completely impossible and unrealistic. Bad results occur even when the advice and treatment are appropriate and properly carried out.

Ironically, in a practical sense, one protection a doctor has against being sued on any grounds, as well as on informed consent, doesn't really relate to the technical quality of treatment at all but depends on a recognition of the principle of patient autonomy underlying informed consent. It should not be thought that the duty to disclose information is relevant only to compensation claims against doctors. Fuller disclosure of information may improve the outcome of medical treatment. A patient who understands the nature and implications of the treatment is likely to be more co-operative and to accept a poor result more readily. The patient in fact may be less likely to resort to litigation. Thus rather than opposing and resenting the development of informed consent principles, doctors could see them as a method or approach to enhance their patient care.

43 Robertson, 'Informed Consent to Medical Treatment' (1981) 97 LQR 102, 109-111.

44 Indeed, one commission reports that lawyers accept only about one in every eight claims in which advice is sought; Kennedy, above n 41 at 467.

A specific factor relevant to liability for failure to obtain informed consent which physicians can control is documentation of information given and patient response. This does not mean initials on a mass-produced consent form, expressed in technical terms. In *Gover* the court specifically stated that it gave little weight to a signed consent form and criticised the inadequate recording practice of the doctor.[45] The issue is the information given and the patient's comprehension. Giving information in spoken, written or even video form is fine, as long as it is comprehensible to the patient, there is adequate discussion of it with the patient to assess understanding, and some record is kept of this having taken place and its content. It is certainly of concern that studies show that patients may not understand or recall information given to them about their treatment.[46] However, it is equally clear that increased attention to a patient's information needs can improve the recall and the understanding. Eagleson's article in *Symposia*[47] has some good examples of consent forms and a discussion of some doctor/patient communication problems and how to overcome them.

Doctors may sometimes interpret lack of questions from a patient as implying understanding and agreement when in fact it only denotes confusion, uncertainty and a state of intimidation. No questions from a patient can also be interpreted as a lack of desire for information, and this is an area that often concerns doctors, who feel that the legal development of informed consent compels them to force feed patients with unwanted information. It is quite clear from the South Australian decisions that a patient can waive the right to information and relieve the doctor from giving information which would otherwise be necessary.

> 'A doctor is not required to inflict on . . . 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'.[48]

The difficulty with this area is one of misinterpretation. Doctors, for a number of reasons, may perceive a patient as not wanting information, when the patient does want information but does not know what, when, whom or how to ask. In one study in the United States it was found that 72% of the public wanted shared decision-making on medical care, while 88% of the doctors believed that patients wanted them to choose.[49] To a patient, seeking and receiving medical care is a complex emotional event. Even relatively sophisticated consumers of medical services become emotionally dependent on a doctor and are easily intimidated, especially if a doctor responds defensively and treats a request for information defensively, as an expression of lack of confidence by the patient. Thus, a doctor should be very sure before concluding that a patient is affirmatively rejecting information.

Another area of misunderstanding about the implications of informed consent for medical practice is the area sometimes called therapeutic privilege, when, in the doctors view, it is not in the best interests of a

45 Above n 1 at 554, 558.
46 Brazier, above n 12 at 175, 177.
47 Above n 5.
48 *F* v *R*, above n 1 at 193.
49 Somerville, above n 8 at 2, Brazier above n 12 at 174, 178.

patient to have certain information about treatment. The problem arises, really, in two situations. The first is where the patient, by reason of mental or emotional state, will be unable to use the information in any rational way. The South Australian Supreme Court has recognised this as a relevant factor[50]- and the decision in *Battersby* v *Tottman* was in favour of a doctor who withheld highly significant information (a risk of blindness) from a patient on the grounds of harm which the doctor, in his professional judgment, foresaw would be caused by disclosure.

The more difficult situation arises when, in a physician's clinical judgment, a certain treatment or procedure is in a patient's best interest but the doctor believes that, if certain information is disclosed, the patient will refuse this needed or beneficial treatment. This directly challenges the fundamental value of patient autonomy which is central to the legal and ethical principle of informed consent. If a person chooses to live with pain and discomfort and inconvenience rather than undergo treatment, especially surgery, that is up to the patient to choose. A doctor who claims to know what is in the best interest of the patient simply cannot do so.

In rejecting a requirement that doctors must disclose everything of importance to the particular patient, courts and commentators point out that it is impossible and unrealistic to expect a doctor to know what will motivate that particular patient and hence to anticipate unique individual information needs. That same logic supports rejection of any view of therapeutic privilege that would allow a doctor broad scope to withhold information in light of the doctor's view of a patient's best interests. Only the patient can know what the patient's best interests are.

A physician who withholds information from a competent adult patient on this basis may be on shaky legal ground in South Australia. The courts have certainly recognised the need for a balance between the patient's right to self-determination and the benevolent paternalism of doctors, but have insisted that it is for the courts to strike the balance that the community requires and that courts are not bound by clinical medical judgment on this point.

5. CONCLUSION

If doctors and their legal advisers are relying on s8 to provide some immunity or protection from being sued at all, they are sadly mistaken. If they see it as creating a new general standard of liability regarding informed consent claims, displacing the common law standard with a significantly less onerous requirement for a doctor's conduct, they are also likely to be mistaken. The actual terms of the legislation are ambiguous at best. It is unlikely that a court will treat s8 as effectively and completely displacing a clear and carefully developed common law standard. As can be seen from the discussion above, there are many important factors in a claim brought against a doctor on informed consent grounds which are dealt with clearly in cases but are not considered in s8.

The common law has placed a substantial burden on any plaintiff who raises an informed consent claim against a physician. It is still possible for doctors to blunder pretty badly in handling the information needs of their patients without being legally liable.

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50 *F* v *R*, above n 1 at 193.