THE DOCTRINE OF INFORMED CONSENT IN THE UNITED STATES, ENGLAND, AUSTRALIA AND MALAYSIA : A COMPARATIVE CASE ANALYSIS

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ABSTRACT

The doctrine of informed consent in relation to medical treatment arose from the recognition that a patient has a right to self-determination, that is a right to determine what he shall subject his body to. The recognition of this human right logically carries with it the recognition of a correlative duty on the part of a doctor to provide his patient with sufficient information about the nature and risks of any proposed treatment. Such information is vital so that the patient may make an "informed" choice on what treatment, if any, to undergo. The main issue that is of judicial concern is what should be the precise amount and degree of information to be given to the patient regarding the treatment. If everything is revealed to the patient, it has to be considered that this might scare the patient unnecessarily and caused him to refuse treatment that may be beneficial for his well-being. Should the degree of information given by the doctor vary according to individual patient and circumstances? If so, the question remains whether the doctor is in the best position to decide how much information to offer to the patient. Thus, in framing the extent of the duty to disclose risks inherent in proposed treatment by doctors, how far the role of medical judgment is to play is a complex issue. The principle of "the doctor knows best" has to be carefully weighed against the right of self determination of the patient. The doctrine of informed consent has developed particularly, in the United States and throughout the common law world. The purpose of this research is to trace the development and existence of this doctrine in various countries, namely, the United States, England, Australia and Malaysia. How far this doctrine has upheld the principle of patient autonomy in these countries will also be considered and weighed against the firmly rooted principle of medical paternalism that currently exist in English law.

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INTRODUCTION

Informed consent has been of current interest as the community claimed greater participation in decision making. This is stimulated by growing media publicity and public awareness of medical procedures and surgical operations including the things that can go wrong. Advances in medical science have also increased the range of illnesses which can be treated and expanded the number of such treatments. As patients become more educated about medical procedures, they want to be given more information on which to base their decisions concerning the treatments which they wish to undertake.

The doctrine of informed consent presupposes a patient to be given a full and genuine understanding of the nature, purpose and likely effects of the proposed treatment. In allowing this to occur, the law has much difficulty in balancing the rights of the patient on one hand, and the rights of the doctor, on the other. The patient expects the law to give him dignity, respect, independence, autonomy, information and self-determination. If these

principles have been violated, the patient expects to be able to sought legal redress. Likewise, the doctor expects the law to offer him dignity, respect, autonomy and judgment. Since he has to observe demanding ethics as well as professional standards and heavy responsibilities, the doctor expects to be entitled to be immune from legal liability.

DEFINITION OF THE DOCTRINE OF INFORMED CONSENT

The doctrine of informed consent embodies the general principle that a person has a right to determine whether or not to undergo any medical procedure. A doctor should give a patient sufficient information for him to understand the nature of any proposed treatment, its implications and risks, and the consequences of not taking the treatment. In the light of that information, it is the patient who should decide what treatment, if any, he or she will undertake. The violation of the right to informed consent triggers a "claim" by a patient against a doctor for failure to give him sufficient information about a proposed medical treatment so as to provide him with the opportunity of making an "informed" or "rational" choice as to whether to undergo the treatment."[1]

THE RATIONALE BEHIND THE DOCTRINE OF INFORMED CONSENT

The rationale behind the development of the doctrine of informed consent is basically to promote individual autonomy which means that the decision to undergo treatment is the patient's not the doctor's. The doctrine further encourages rational decision-making by ensuring that the patient is given sufficient information to make good decision. In other words, the doctrine clearly gives recognition to the patient's right to self-determination.

Meisel stated that the doctrine of informed consent "protects the patient's right to determine his or her destiny in medical matters; it guards against overreaching on the part of the physician; it protects his physical and psychic integrity and thus his privacy; and it compensates him both for affronts to his dignity and for the untoward consequences of medical care."[2]

THE POSITION IN THE UNITED STATES OF AMERICA

The doctrine of informed consent owes its origins in the United States of America through the assertion of an eminent American jurist, Justice Benjamin Cardozo, in *Schloendorff v Society of New York Hospital*[3] where His Honour stated that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages."[4] Essentially, Justice Cardozo was restating the ancient common law principle that an unauthorised touching constitutes trespass to the person.[5] Implicitly, the statement above embodies the general principle of the patient's right to self-determination which is central to the doctrine of informed consent.

Later, Justice Cardozo's dictum was applied in *Salgo v Leland Stanford Jr University Board of Trustees*[6]. In *Salgo,* the doctor failed to warn his patient of the risk of paralysis

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[1] Robertson, G. ,"Informed Consent to Medical Treatment" (Jan 1981) 97 LQR 102.
[2] Meisel , A. , 'The Exceptions to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decision-Making" , (1979) Wisc. Law Rev. 413 at pp. 414 - 415.
[3] 105 N.E. 92 (N.Y. 1914).
[4] Ibid. at p. 93.
[5] E.g. *Cole v Turner* (1704) 6 Mod. 149.
[6] 317 P. 2d 1093 (1960).

inherent in the performance of a translumbar aortography, and as result of the operation the patient suffered severe paralysis of the lower limbs. The patient claimed that doctor was negligent in failing to warn of the risk of paralysis. The court held that "[a] physician [would] violate his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment .... full disclosure of facts [is] necessary to an informed consent."[7] This statement clearly acknowledged that a patient needs adequate information about the nature of the proposed treatment, its risks and feasible alternatives in order to make an intelligent choice about whether or not to undergo it. However, the court further added that the content of the disclosure was a matter for professional medical judgment. This means that although the patient should receive information about the proposed treatment, the kind of information to be imparted would rest in the hands of the doctors involved.[8]

Salgo was closely followed by the Supreme Court of Kansas in *Natanson v Kline* [9]. In *Natanson*, the plaintiff suffered injuries as a result of cobalt therapy which was performed to reduce risk of breast cancer following a mastectomy. She sued the radiologist in negligence for failing to warn her of the risks inherent in the therapy. In the course of its judgment, the Supreme Court of Kansas enunciated the rule that the physician is under a duty, inter alia, to make reasonable disclosure to his patient of risks and dangers incident to the proposed treatment. The Court further approved the *dicta* in *Salgo* by holding that what information ought to be disclosed to the patient still rests with the doctors. The

[7] Ibid. at p. 181.
[8] Id.

doctor was under a duty to make a "reasonable" disclosure of inherent risks in the proposed treatment. The question of what was "reasonable" in the particular circumstances is to be decided objectively. Therefore, the relevant question to be asked is *"whether the defendant had acted as a reasonable and prudent doctor would have acted in similar circumstances in deciding not to inform the patient of the particular risk?"*[10]

After *Natanson*, the doctrine of informed consent developed along these lines for the next 12 years. During these years, the courts have accepted that in order to determine what should a doctor disclose to his patient in relation to the inherent risks of proposed treatment, evidence of what a reasonable doctor would have done in similar circumstances would be determinative. This means that testimony by medical experts was required. The need for a medical expert to testify suggests that how much information to be imparted to the patient is a matter of medical judgment. In a way, it would seem that the doctrine of informed consent at this juncture was a myth as there cannot exist the right to patient's self-determination if the information to be imparted is determined by the doctors themselves. This dissatisfaction of how the doctrine of informed consent was taking shape was eminent in the case of *Canterbury v Spence.*[11] In *Canterbury,* the plaintiff suffered paralysis as a result of undergoing a laminectomy. He claimed that the doctor was negligent in failing to warn him of the risk of paralysis. In determining the scope of the doctor's duty to disclose such information, Robinson J. said that "[r]espect for the patient's right of self determination on a particular therapy demands a standard set by law

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[9] 186 Kan. 393, 350 P. 2d 1093 (1960)
[10] See above note 1, at p. 105.

for a physician rather than one which physicians may or may not impose upon themselves."[12] The court at this juncture felt that to permit the physician to determine what information need to be disclosed by reference either to his own personal standards or to the medical profession would in many ways undercut the patient's right to have the available information he might need to make a decision for himself. Hence, it was decided that standard of disclosure based on medical judgment was merely a facade and that to determine what risks a person regard as material should be determined without the aid of medical science.

The court, further accepted that the doctor must disclose all "material" risks inherent in a proposed treatment. Before *Canterbury*, what is "material" would be a matter of medical judgment but in *Canterbury*, the question is to be determined by the "prudent patient" test. Robinson J. stated that "[a] risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in determining whether or not to forego the proposed theraphy."[13] It would appear from this statement that the doctor has a duty to disclose all material risks and the test of materiality is not whether the patient himself would attach any significance to it but whether a reasonable person in the patient's position would have done so. However, to court went on to recognise certain exceptions to this duty of disclosure. The most important is that of "therapeutic privilege".[14] This

[11] 464 F. 2d 772 (D.C.Cir. 1972)
[12] Ibid. at p. 784.
[13] Id. at p. 787.
[14] Id. at p. 788.

exception allows the doctor to withhold information from his patient concerning risks of proposed treatment if it can be established by means of medical evidence that disclosure of this information would posed a serious threat of psychological treatment to the patient. Nevertheless, the court stated that such privilege should not be used by the physician to substitute his judgment for the patient's. Where the physician expects that full disclosure would cause the patient to forego treatment, a proper case for its application does not exist. Rather, the privilege properly operates only when the communication of information to the patient, based on sound medical judgment, would cause the patient to become distraught that he would not be able to make a rational decision.[15]

Clearly, the decision in *Canterbury* reflects a shift in the law towards greater respect for patient autonomy. *Canterbury* was closely followed in judgments by the Supreme Court of California and Rhode Island.[16] However, it should be noted that majority of the jurisdictions in the United States were contented with the *pre-Canterbury* approach, that is, having a doctrine of informed consent that is regulated by medical experts rather than a doctrine of consent based on full protection of the self-determination right.[17]

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[15] Id. at p. 789.
[16] For instance, in *Cobbs v Grant* 104 Cal Rptr. 505 (1972) ; *Wilkinson v Vesey* 110 R.I. 606 (1972).
[17] Jurisdictions that have adopted the *Canterbury* approach were California, Rhode Island, Columbia, Louisiana, New Mexico, New York, Oregon, Pennsylvania, Washington and Winsconsin. Jurisdictions that still maintained the *pre-Canterbury* approach would be Alabama, Alaska, Arizona, Colorado, Delaware, Florida, Hawaii, Illonois, Iowa, Kansas, Maryland, Massachusetts, Michigan, Mississipi,