BIOETHICS OUTLOOK

John Plunkett Centre for Ethics in Health Care

Volume 5 Number 2 *June 1994*

In this issue

♦ At our first Intensive Bioethics Course held recently at Manly, we invited Ms Paddy Bergin, a member of the Sydney Bar, to comment on the High Court's 'landmark' decision in 1992 in *Rogers v Whitaker*. Ms Bergin argued that that decision was one to be expected as it strengthened what had already been said about a doctor's duty to disclose from some earlier Australian cases. Ms Bergin then illustrated how the Whitaker principle has been applied in recent cases. Though we do not intend to publish all the papers from this course (it was not a conference but a structured introduction to ethical reflection about health care), our first article is an abridged version of that talk.

♦ In the last issue, Gerald Gleeson explained the notion of 'intrinsic evil', so central in *Veritatis Splendor*. In this issue, he shows why it matters that we recognize some ways of acting as intrinsically evil. He argues that, without that understanding, the significance of the principle that 'it is wrong to do evil that good may come' may be lost.

♦ On the back page, instead of our usual "Notes", we reprint a new protocol concerning the use of Cardiopulmonary Resuscitation which was recently adopted by the Board of St Vincent's Hospital in Sydney. This protocol reflects the way a particular group of people at a particular hospital understands the issues; however, it may be of some interest (and even assistance) to others with similar concerns. The Bioethics Committee of the Hospital welcomes comments on the protocol.

A Doctor's Duty to Disclose

Paddy Bergin

Legal Background

In 1992, in the case known as *Rogers v Whitaker*, the High Court said that a doctor must warn a patient about the material risks of treatment. The High Court said that a risk is material:

> *"... if in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, will be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it."* [1]

The legal background to the Court's decision had been developing in this country for some time. The law has long held doctors liable for failing to warn patients about material risks which eventuate. (That statement needs to be qualified as, of course, different tests have applied over the years, and there have been cases where doctors have not been held liable because of a failure by the plaintiff to prove some of the essential elements of the case. Those are instances where doctors have failed to warn patients of material risks but patients have failed to establish that if that material risk had been brought to their attention they would have refused to go ahead with the suggested treatment or procedure.)

As far back as 1980, in *Albrighton v Royal Prince Alfred Hospital*[2], Reynolds JA. said:

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

And in 1982, in *F v R*[3] (in which a surgeon failed to warn the plaintiffs of the chance that ligated tubes might regenerate) medical practice at the time was held not to be the test. King J. said:

> *"The ultimate question, however, is not whether the defendant's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law. That is a question for the court and the duty of deciding cannot be delegated to any profession or group in the community.*
>
> *It is for the court to decide what a careful and responsible doctor would explain to the patient in the circumstances, and I do not regard as decisive the opinions of the medical witnesses on the point or the existence of a practice of non-disclosure in a section of the profession. If the court thought that that practice involved a failure to exercise reasonable care towards the patient, I would regard it as its duty to give effect to that view."*

Justice Bollen said:

> *"Expert evidence will assist the court. But in the end it is the court which must say whether there was a duty owed and a breach of it. The court will have been guided and assisted by the expert evidence. It will afford great weight to the expert evidence. Sometimes its decision will be the same as it would have been had it accepted dictation. But the court does not merely follow expert evidence slavishly to a decision. The court considers and weighs up all admissible evidence which it has received. If the court did merely follow the path apparently pointed by expert evidence with no critical consideration of it and the other evidence, it would abdicate its duty to decide, on the evidence, whether in law a duty existed and had been discharged."*

You have no doubt read in the pre-reading materials for this course the analysis given by Dr Tobin of the *Sidaway* decision.[4] If one compares the statements in the dissenting speech of Lord Scarman with the statements by the High Court there is very little difference. However, you may think that the High Court's exposition is one of greater clarity.

So, long before *Rogers v Whitaker*, we had judicial guidance on what is now the *Whitaker* principle, that is, that expert evidence would be of assistance in medical negligence cases but not generally in cases about whether the patient has been given all relevant information.

Application to Later Cases

What has happened in the Courts since *Rogers v Whitaker?* A recent decision in the Supreme Court of New South Wales, *Dunning v Scheibner*,[5] applied the *Whitaker* principle in the following circumstances. Mrs. Dunning was born on 17th September 1957 and at a relatively early age had a tattoo comprising the name of her boyfriend placed on her right shoulder. Having become disenchanted with that tattoo she had it "revised" by arranging for a small bird to be tattooed over the name. She was still unhappy with the tattoo and consulted a plastic surgeon for its removal. She was treated by way of excision and skin graft but was left with a prominent scar which she considered to be ugly. Notwithstanding that experience, some years later she decided to have further tattoos which were described as "bikers tattoos".

After two years, by which time she had a daughter, she decided that she no longer wanted the tattoos. She felt concern about having to explain them to her daughter as she grew up and was worried about the embarrassment which might arise. In 1983, while watching the Mike Walsh Show on television, she observed a segment in the course of which there was mention of a new technique for the removal of tattoos by way of laser. She thereafter consulted the defendant, Dr. Scheibner.

Mrs. Dunning gave evidence that she told Dr. Scheibner that she was not happy with the scars

that had been left by the previous procedures she had in respect of her tattoos. Her evidence was that the doctor said "It's a terrible scar. The laser technique would be nothing like that." Mrs. Dunning also told the court that she was shown some photographs comprising before and after shots which revealed normal skin with the tattoo completely removed. She denied being shown any photographs of scarring or other problems as a result of the laser treatment.

It is apparent that Mrs Dunning underwent serious pain for which she was treated by pethidine injections, digesics and Codral forte, prescribed by her general practitioner. By the time of her last visit for her procedures with the laser the scarring was "very obvious and ugly". Dr Scheibner then suggested a referral to a plastic surgeon for scar revision. Mrs Dunning did not see the plastic surgeon as she was not wanting to have any further pain or to run the risk of more scarring. Wood J., in viewing the photographs that were taken in 1987, was of the view that they revealed "extremely ugly, disfiguring, hypertrophic raised scarring, with some pigment still present". Mrs Dunning also suffered from psychiatric reaction, suffering from depression and panic attacks.

Mrs Dunning established that if she had been warned about the scarring of the type that she subsequently suffered she would not have gone ahead with the procedure. She would rather have had the colours on her arms than the grotesque scars that she now had.

Use of Consent Forms

Mrs Dunning had signed forms of consent to the treatment at the hospital which included words to the effect: "The risks involved in undergoing the operation have been fully explained to me by Dr. Scheibner and I freely accept those risks." But she denied having read that section of the document and indicated that she thought she was doing no more than signing herself in for treatment as a day patient.

The trial judge noted that Dr Scheibner did not have any "contemporary record of the conversation or of the information provided, and did not follow any practice of either showing to a patient, or having a patient sign, a document explaining the procedure and listing the possible complications".

His Honour found that Mrs Dunning was not cautioned as to the substantial risk of scarring which the procedure carried. He also found that she was not warned that the results were uncertain but depended on the depth and size of the tattoos and their location. His Honour found that she was not warned that the skin appearance would not be normal after treatment, in texture or colour and that the results were not as good with professional tattoos or that the tattoos should be treated in small segments over twelve months.

His Honour also found that she was not shown photographs of an unfavourable result or cautioned that the treatment did not offer a miracle cure. He also found that it was not sufficiently explained to the plaintiff that the laser would cause deep burns to the skin in the areas of the tattoos and that the procedure carried with it all the usual risks of infection, permanent scarring, and altered skin appearance, associated with third degree burns.

He said:

"The professional relationship which exists between a patient and medical practitioner is one which attracts a duty of care in relation to the treatment procedure, and in relation to the provision of that degree of knowledge concerning the procedure under contemplation which is necessary to enable the plaintiff to make an informed decision to proceed: ***Rogers v Whitaker*** *."*[6]

Material Risks

After then citing the judgment of Mason CJ., Brennan, Dawson, Toohey & McHugh JJ., His Honour later, under the heading "Informed Consent" said:

"The present case must be considered in the light of the fact that the procedure carried out was purely elective, its purpose being to overcome the disfiguring cosmetic effects of the tattoos, and carried with it, on the defendant's own concession, a 30% incidence of hypertrophic scarring. The material risks

involved were that a worse disfigurement would arise in the form of ugly scarring, and that previously healthy skin would be left damaged. It can scarcely be denied that a reasonable person, in the plaintiff's position, if warned of those risks, would have been likely to attach significance to them. Nor could it be sensibly argued that the defendant should have been otherwise than aware that the plaintiff, if warned of those risks, would have been likely to attach significance to them."

This, then, was the direct application of what the High Court had described as the material risk in *Rogers v Whitaker*. Importantly Wood J. also said:

"The need for suitable warnings and information in this connection was obvious, and did not depend upon expert evidence."

One may infer that, had it not been obvious, then there may be a place for expert evidence in respect of suitable warnings. The defendant, in this case, was found to have failed in the duty of care imposed on her sufficiently to explain the procedure, the risks associated with it, and the outcome which could be expected.

Two recent Queensland cases also applied the *Whitaker* principle. In the first, *Shaw v Langley*[7], the plaintiff was a 29 year old married woman with a son aged nine. Following the birth of this child, her breasts had changed shape and significantly reduced in size. The plaintiff investigated having breast enlargement and her general practitioner referred her to the defendant, Dr. Langley.

The court accepted that Mrs Shaw was informed by the doctor that the operation was simple, involving a cut in the sub-mammary crease of each of her breasts through which prostheses would be inserted. A particular type of prostheses was suggested as suitable. Mrs Shaw was left with the impression that the procedure was simple and straight forward. She decided to proceed with the augmentation.

The doctor gave evidence that he told Mrs Shaw: (i) of the possibilities of fluid or blood accumulating in the breast; (ii) that a capsule might form in the breast; and (iii) there was a risk of mild scarring and altered sensation. However the court did not accept this evidence.

Mrs Shaw was left with scarring on her breasts instead of in the sub-mammary creases. The breasts were asymmetrical with the nipples pointing in different directions. The breasts became infected and capsulated. She had to undergo further surgery and was left with numb and sensitive breasts.

Mentioning Complications Insufficient

In this case expert evidence was called by both the plaintiff and the defendant, and these doctors were in agreement that it was insufficient to simply mention a relevant complication by its professional name. The court found:

"A surgeon must explain it and take care to see the patient truly understands the nature and possible consequences of the complication in question ... depending on the circumstances either ... lengthy discussion of complications followed up by a letter emphasising the principal areas of concern or ... careful discussion which thoroughly canvasses all complications."

His Honour, however, found consistently with the *Whitaker* principle:

"While medical practice can provide a guide to a proper adjudication in an "omission to warn" case, it is for the court to decide an appropriate standard of care after giving full weight to the most important factor that a prospective patient is entitled to make the decision as to whether surgery shall take place. The court was satisfied that the doctor did not mention capsulation, infection, asymmetry, pain and numbness prior to the operation."[8]

The second case *Tekanawa v Millican*[9] is a case involving abdominoplasty surgery. There was no issue of negligence in the performance of the operation in this case. The whole of the case was based on an allegation that the doctor breached the duty he owed to the plaintiff to advise of the likely consequences of the surgery.

(Contd. page 9)

"Intrinsic" evil - why it matters

Gerald P. Gleeson

The encyclical *Veritatis Splendor* re-asserts that there are certain kinds of human action which are wrong and, moreover, always wrong: they are said to involve an inherent evil which can in no way be eliminated or "redeemed" by the exigencies of exceptional circumstances, by good consequences or by noble intentions. The importance of this claim that some kinds of action are "intrinsically evil" is not that it resolves controversial moral debates without further ado, but that it epitomises the entire way in which the morality - the rightness or wrongness - of human action should be understood. It is the moral wisdom behind the notion of "intrinsic evil" that matters most, and that I wish to explore in the second part of this essay.[1]

I

The heart of human action

The opposite of intrinsically evil is, presumably, intrinsically good. There are many kinds of good and evil. In ethics our concern is good and evil in the things we do, and of the many different ways in which human conduct may be good or bad, it is crucial to know what matters most: what, if anything, is it that is "intrinsic" to human action and its moral evaluation? If, for example, we think about what it is to act rightly, it is evident that many factors - our motives, our intentions, what we actually do, the resulting consequences, the means we choose etc. - are all relevant. Clearly for an action to be truly right, it must be good in every respect.

But of these many factors one is more critical than the rest, because it touches most closely upon what it is to be a moral agent acting well. According to *Veritatis Splendor* this crucial factor is one's "moral object" - what one choses and intentionally does, either as an end in itself or as a means to a further end. The term "moral object" derives from scholastic philosophy, and may now be somewhat misleading; one's moral object is not a thing! "Moral objective" may be a more illuminating term.

To trace the excellence of human action to its source, I must establish what my moral objective really is, what it is I am purposing to achieve in and through my action. If my goal is to express gratitude to a friend for a particular kindness shown to me and I resolve to do this by giving a gift, then my "moral objective" is to express gratitude by gift giving. That is the complete answer to the questions: what are you doing, and why? Clearly, there is an "intrinsic goodness" in this moral objective, which is quite distinct from the good consequences which may flow from the gift giving (or even the bad consequences, should I happen to select a gift my friend detests!). The key to the goodness of my objective in this example is that the action I perform (giving a gift) can be, and is, an appropriate way of realising my objective (expressing gratitude).

A "moral objective" is not a particular kind of objective (as if expressing gratitude was a "moral" objective, whereas handing over a bottle of perfume was a non-moral objective). My moral objective is simply my objective in acting (in handing over the perfume), in so far as it is subject to moral evaluation. My objective is what I am doing; it is a moral objective since what I am doing is what I am responsible for, and what I am doing indicates what goals I have chosen to make my own and, thereby, what goods and evils I have chosen to characterise myself by as the kind of person I am.

Moral Objectives

The notion of a moral objective is central to the Catholic moral tradition. It focuses our attention on the moral reasoning and choice from which

my action proceeds. In the tradition of Thomas Aquinas, genuine human action must be voluntary, free and intentional, that is to say, it must originate in a person's reason and will, in "deliberative choice". There is all the difference in the world between my killing another, and my - non-voluntarily - causing the death of another (by accident, by misadventure, by being forced against my will, etc.). Utilitarian and proportionalist ethical theories tend to ignore this distinction between voluntary action and causation which, for Thomas, is crucial to sound moral understanding.

The term "objective" highlights the way intention and choice is purposive; it is what gives shape and direction to my action. In many instances, the "same actions" may embody very different intentions and objectives. According to Aquinas, human beings always act on objectives which involve what seems to them to be good or conducive to some good (though we are often mistaken in our judgments about the good). In order to act well, my objectives (both immediate and more distant) must be good and rightly ordered.

Most importantly, the emphasis on my objective in acting ensures that we conduct moral evaluation from the first-person perspective of someone before he or she acts. In acting well (or ill) I can only be held accountable for that which lies within my power as an agent: the knowledge I ought to possess, the awareness of foreseeable consequences I ought to have, the state of my passions, desires and habits, etc. and above all, the quality of the practical reasoning and choice by which I order the means I chose to the goals I am pursuing.

This purposive, agent-centred perspective is quite unlike the detached, neutral perspective of an (omniscient?) observer who would track the various consequences of my action. This is the perspective of utilitarian and consequentialist theories which propose to measure rightness according to the goodness and badness of outcomes: actions are right - either in general or on occasion - if they produce more good than harm. But such calculations cannot be carried out - in principle or in practice. At most, they can be approximated on the model of decision theories which assess risk and conduct cost-benefit analyses.

Excellence in human action can only be measured in terms of the kind of excellence open to human beings as responsible and voluntary agents. What is "intrinsic" to human actions as human (not as physical events) is choice. That is why a study of excellence in human action is a study of the conditions for excellence in choice. It is because of this agent-perspective that the Catholic moral tradition holds that human actions cannot be defined "physically" or merely behaviourally, as the performing of this operation, the taking of these pills, the causing of someone's death, the uttering of these words, and so on. Merely behavioural descriptions of "events" do not tell us what a person is really doing because they do not tell us what is the point of their action. To understand what someone is doing we must know what is intended, what purpose the action is meant to serve.

By "intention" here is meant the purposive reasoning which culminates in someone's conclusion about what ought to be done as a means to his or her end. The "essence" of moral action - what is "intrinsic" to it - is that it be purposeful action which embodies a choice with respect to what presents itself as good in relation to human living. It follows that on occasion, some features of my action - some of its foreseeable consequences - may be, as Aquinas put it, "outside my intention". Thus, when a surgeon removes a pregnant woman's cancerous uterus his action embodies his choice of the most suitable means available for saving her life - "that's what he's up to, saving life". The death of the fetus is a side-effect, and no part of his morally upright project, not a means to his end.

II

Wrong "in advance"

Since my moral objective constitutes the heart of my action, there is at least one way of identifying kinds of action which can be known in advance to be wrong: viz. if they embody an inherently flawed objective. Such an inherent flaw could arise in either of two ways: either (a) I might resolve on an objective which (though

it may seem to me good) is really at odds with human dignity and goodness; or (b) I might resolve on inappropriate ways of realising what is otherwise a good objective. For example - the first kind of flaw - I might resolve upon a life centred on physical pleasure (living to eat and drink well), a disordered objective which mistakes the role of pleasure in human life.

The second kind of flaw is exemplified in euthanasia: the project (or objective) is to end someone's suffering precisely by ending his life. Within this project, causing death is an identifiable object of choice as the selected means to an admittedly good end. Yet, this is a disordered choice or intention because there is an inherent flaw or internal contradiction in the project of caring for someone by killing him.

Likewise, to force sexual intercourse upon another is an "intrinsic" evil because force which overcomes another's freedom contradicts the very nature of human sexuality. In these cases we do not need to assess the short and long term consequences, or to weigh up various goods and evils that result. It would be obscene to ask, did this rape do more harm than good? In choosing to care for someone by taking his life, or to engage in sexual "union" by force, the wrongdoing is "intrinsic" - inherent in the very course of action one undertakes, irrespective of any other "extrinsic" considerations.

Human conduct which is "intrinsically wrong" is conduct which embodies a disordered objective, the choice of an action which contradicts the good it is supposed to realise or promote. It may seem strange to locate the essence of moral wrongdoing within the disordered objective of the agent - shouldn't the suffering of the victim of rape or murder be the focus of our moral concern? Indeed, but the suffering of the victim cannot be appreciated correctly apart from the wrongdoing of the agent. It is the presence of willful wrongdoing, rather than accident or natural causes, which determines the kind of evil a victim suffers. To be struck down by illness is one kind of evil, to be violated by the criminal act of another, to be used as a means, not respected as an end in oneself, is a different and far worse kind of evil, one which strikes at the heart of what it is to be a human being. It follows that in the final analysis the moral evil of murder, for instance, consists not just in the (presumably) bad consequence of someone's untimely death, nor simply in the violation of a norm or law, but in the fact that an act of killing embodies that disordered intention by which one person makes another person's death his or her objective as a means to an end, irrespective of how noble (to prevent suffering) or ignoble (to satisfy feelings of jealousy) that end may be.[2]

The paradox of utilitarianism

Paradoxically, it is the utilitarian focus on outcomes alone, on the suffering of victims, which undermines respect for persons. If suffering alone is the focus, then the question can always be asked whether, in this instance, less suffering will result over all if someone's dignity and rights are violated, than if they are not. Only an ethics which focuses on the intentions of agents and on the choice for which they are accountable, and so acknowledges the possibility of "intrinsically evil" choices - and prohibit them - will truly protect potential victims.

Intrinsically evil actions embody an inherent contradiction with respect the true goals of human action. In *Veritatis Splendor* John Paul II, following *Gaudium et Spes* 27, groups such intrinsic evils within the categories of "whatever is hostile to life itself,... whatever violates the integrity of the human person,... whatever is offensive to human dignity" (VS 80). Clearly, many questions remain to be answered. How is the correct moral description (objective) of a human action to be determined? Which actions are "hostile to life itself", and in which circumstances, and which only seem to be? How can we tell what is action and what is consequence, what is chosen means and what is side-effect? Just acknowledging the possibility of intrinsically disordered intentions - e.g. the choice of action hostile to life - does not establish which particular actions embody this intention. However, this acknowledgment does tell us where to focus our inquiry. It is chiefly by examining the deliberation - the purposive reasoning - which culminates in choice that the rightness or wrongness of my moral objectives, and so of actions, can be determined. My choices reveal what I am up to, what goods matter to me and in what order of priority.

It is because some kinds of actions embody intrinsically disordered choices that these kinds of action are always prohibited (e.g. killing the innocent). Yet it should also be clear that morality is not ultimately about norms but about what norms protect, and secondly, that intentions must be embodied in actions in the particularity of their circumstances. Self-defence against a deranged ("guiltless") attacker who is not responsible for his actions may have to include the choice of defensive measures which lead to his death. An abstract statement of what constitutes a flawed intention cannot substitute for close moral analysis of particular cases in order to determine the true character of one's moral objective. The complex questions surrounding the treatment of ectopic pregnancies or the early induction of an anancephalic fetus remain just that: complex.

The circularity of good and evil

If a moral objective is inherently disordered, the explanation of its (intrinsic) disorder will involve a circularity, for the explanation will attempt to show why an understanding of a good end (e.g. caring for the terminally ill; marital sexuality) rules out certain means as incompatible with it (taking life; contraception). The recognition of intrinsic evils thus presupposes a grasp of the intrinsic goods which constitute the goals and context of human action, and the parameters of the human good. Hence, with respect to the categories noted above by *Gaudium et Spes*, life itself, and the integrity and dignity of the human person, play the role of fundamental goods. "Moral norms are not ends in themselves but point to a conception of human flourishing and dignity that they tacitly embody."[3]

In short, one cannot prove that a certain kind of action is inherently wrong independently of bringing someone to recognise the goods and human values which it contradicts. To understand why euthanasia is wrong is to understand what it is to care for, and stand in solidarity with, the sick and dying. To understand that sexual union ought to be mutually chosen in freedom is ipso facto to understand the inherent evil of rape; to understand the nature of marital fidelity is to understand the inherent evil of adultery.

In recognising certain kinds of actions as intrinsically evil - because they embody disordered choices and intentions - we recognise one kind of "boundary" or "horizon" which marks out a definite moral understanding or conception of human life and community. This boundary is expressed in the traditional Christian principle that it is wrong to do evil that good may come. This principle follows from the conception of human agency as voluntary, responsible action shaped by a moral objective. This principle epitomises the kind of moral agents we are called to be, viz. agents with integrity whose moral choices do not involve inherent contradictions, who do not lie or steal or act unfaithfully, in order to achieve their (good) ends. Robbing the bank cannot be a just way of feeding the poor; cheating in one's exams cannot be an honest way of attaining one's professional qualifications.

It is because we are called to moral integrity that wrong doing can never just be prima facie (as proportionalism suggests).[4] Doing wrong is a matter of embracing a disordered moral objective which reflects back on me as a moral agent. Intrinsic evil, one might say, is wrongdoing that "clings to" the agent who has made it his own, irrespective of any good outcomes that may ensue. It is this phenomenon - the way genuine wrongdoing clings to us - of which we all have experience, that the moral wisdom in *Veritatis Splendor* seeks to keep before us.[5]

• • • • • • • • • • •

1 Cf. my 'Just what is an "intrinsic evil"?', *Bioethics Outlook* 5/1 (1994): 1-4.

2 For Aquinas, if self-defence should require killing an assailant, the killing is "outside" my intention since my purpose is properly described as the legitimate use of necessary force, not the death as such of the assailant. By contrast, killing in capital punishment or just warfare is "intentional", but assumes both state authorisation and the fact that the victim has forfeited his right to immunity. Cf. Jean Porter, *The Recovery of Virtue*, (Westminster/John Knox Press: Louisville, Kent., 1990), pp. 128-132.

3 Thomas R. Kopfensteiner, 'Protecting a Dignified Death: A Contemporary Challenge for Moral Reasoning', in *New Theology Review* (1993), p. 6. Cf. John Finnis's remark that "nobody has an inviolable right to life unless there is an exceptionless moral norm: never choose to kill an innocent human being" ("Beyond the encyclical", in *The Tablet* 8 January, 1994, p. 9).

4 Cf. part I of this study, *Bioethics Outlook* 5/1 (1994).

5 In a further study I hope to take up the complex question of how we can identify which particular actions embody disordered choices.

A Doctor's Duty to Disclose

(Contd from p. 4)

The plaintiff, Mrs Tekanawa, was a 36 year old married woman with four children. She was in good health, weighed 58 kilos and was about 160 centimetres. She was described as a woman who had "obtained satisfaction from her attractiveness and fitness". She became concerned at what she described as a loose pouch-like stomach which would bloat out after eating. She had read about and been told about a surgical procedure referred to as a "tummy tuck". Mrs Tekanawa was left with an extensive and permanent post-operative scar above the pubic area and also above the navel. She alleged that the doctor had told her that she could expect some scarring above the pubic area "... a neat scar along the contour of the abdomen just above the pubic hair and out on to each hip and around the navel." She was not told of any risk of extensive and unsightly scarring above the pubic area or in the vicinity of the navel.

Dr Millican provided Mrs Tekanawa with a copy of a document produced by the Australian Society of Plastic Surgeons entitled "Patient Information on Abdominoplasty." He then explained to her by use of a small hand-drawn diagram what the resulting scar tissue would look like. Mrs Tekanawa had informed the doctor that she was particularly concerned about the type of scarring which might result. It appears that the court took the view that the document provided by the College of Surgeons did not assist the defendant's case and it seemed to the trial judge to be "almost misleading" in some respects. In this case it appears the court may have gone a step further and found that the duty to warn is even higher when the procedure being contemplated is truly elective and is not required for therapeutic reasons.[10]

The implications regarding the giving of information

A doctor must inform the patient of material risks. In discussing the nature of the treatment to be provided, various considerations have been identified as relevant in a number of the decided cases. They may be listed as follows:[11]

(a) **The personality and temperament of the patient and the patient's attitude.** Reasonable care will include an appraisal of the patient's intelligence and temperament and apparent understanding, made in the light of the simplicity or complexity of the recommendation the doctor is making.

(b) **Whether the patient wants information.** If a patient is apparently keen to be given more information, rather than seeking reassurance, more information should generally be given. If on the other hand, the patient does not want information, the doctor is not required to force it upon him. A nice balance has then to be made in insuring the patient has sufficient information to know that he does not want any more.

(c) **Whether the patient asks questions.** The absence of questions should not be taken as an indication that the patient does not want to know anything. On the other hand, questions may indicate to the doctor the kind of information which the patient regards as material to a decision. In a particular case, a direct question may call for an answer telling of the risk, however slight. There is no overriding obligation to tell the patient absolutely everything if the patient asks to be fully informed; the standard of care is never higher than to act reasonably.

(d) **The patient's level of understanding.** A doctor need not cross-examine the patient exhaustively to ensure that he understands and will remember the advice, but the doctor should give information which he believes the patient will understand after a fair appraisal of the patient's intelligence and temperament.

(e) **The nature of the treatment.** The more drastic the treatment, such as major surgery, the more information is reasonably required. Also, the amount of information reasonably required will be greater if the procedure is purely elective than if the procedure is necessary to preserve the patient's life or health and it is so understood by the patient. It is reasonable to suppose that a patient will not be as interested in the risk of failure or complications if his life or health are not at stake.

(f) **The magnitude of the possible harm.** Reasonable care may require disclosure of a slight risk of serious harm or of a high probability of a less serious complication. It has been suggested that a doctor might assume a patient's knowledge of generally known risks such as the risks of anaesthesia or infection after surgery. However, that might not be a safe assumption, particularly in relation to purely elective surgery and even more particularly in relation to cosmetic surgery, where even remote risks might reasonably count when brought to mind.

(g) **The general surrounding circumstances.** The extent of the duty will be affected by emergency conditions or the absence of the opportunity for detached reflection or calm counselling, and by the existence of alternative sources of advice.

(h) **The doctor's belief on reasonable grounds that the patient's health or welfare might be seriously harmed by being given the information.** A doctor may justifiably withhold information when he judges on reasonable grounds that the patient's health, physical or mental, might be seriously harmed by the information, particularly when the patient is of a nervous or anxious disposition, or if the doctor reasonably judges that the patient's temperament or emotional state is such that he would be unable to make the information a basis for a rational decision. There is a discretion to withhold information on such grounds even if the patient asks questions.[12]

There do however, seem to be other implications of the High Court decision in the field of ethics. We have heard of patient autonomy and of paternalism in the doctor/patient relationship. Those issues are directly relevant when discussing the *Whitaker* principle. In looking to both the practical and legal implications one must remember the following: "In every adult there lurks a child - an eternal child, something that is always becoming, is never completed, and calls for increasing care, attention and education."[13] That lurking child will no doubt have greater say in circumstances where the patient is frightened and worried about the future course of medical treatment. At law contracts are set aside where the agreement reached is one that has been induced by duress or representations that have been made which are misleading or deceptive. And yet here we find the patient required to make his or her own decision at a time when his or her capacity to make such a decision may be affected by extreme anxiety and distress. This may point up the wisdom in not adopting the label "informed consent". The reality is that the consent will be given after disclosure of certain information. Whether what the patient does could be described as "informed consent" is another matter.

Some commentators have called the decision about whether or not to undergo a medical treatment a shared decision.[14] This is an approach to the *Whitaker* principle which, in my view, is erroneous. No matter how much the doctor tries to provide information to the patient, therapeutic privilege aside, it is the patient's decision to proceed with or reject the suggestion of the treatment. It is perhaps a misnomer rather than an error of principle into which these commentators have fallen. What is shared is the information not the decision. As the doctor gives information the patient may respond with other information. There may then be an exchange of further information. This is a sharing of information upon which a decision is made by the patient. The doctor/patient relationship does not lend itself to what takes place in the business world of risk sharing. One cannot, in this arena, have ethical or philosophical risk-spreading. The responsibility to provide the information and to provide proper medical treatment is the doctor's responsibility. The responsibility to make a decision to go ahead with that treatment, therapeutic privilege aside, is that patient's responsibility. They remain separate responsibilities and are not changed by this High Court decision.

The president of the New South Wales Court of Appeal, comparing the old medical practice (or *Bolam*) test with the *Whitaker* principle, put it this way:

> *"The problem with the old test is that it is, in reality, a relic of an earlier time and of earlier ideas of the proper relationship between*

doctors and patients. The notion that doctors know best and that, by standards of their profession, they can determine what patients ought to know, turns the nature of that profession on its head. It is not there for the good of doctors. It is there for the benefit of patients. The only authority and legitimacy of the doctor to intervene in the life and body of the patient is, respectful of the patient's individuality, with the patient's informed consent. That is why a proper development of the law, reflecting the age of basic human rights in which the law now operates, will start at the other end of the equation of consent: just as the Americans do. Ask not what your doctor can do for you. Ask rather what you agree should be done to you with your informed consent."[15]

References

[1] *Rogers v Whitaker* 175 CLR 479 at 490.
[2] (1980) 2 NSWLR 542.
[3] (1982) 29 SASR 437.
[4] (1985) 1 AC 871.
[5] Plaint No. 13776 of 1988 Wood J. 15.2.1994.
[6] (Supra page 58-59).
[7] Unreported Pratt DCJ. District Court, Southport 24.11.1993 No. 485/91.
[8] Case outline extracted from P. Croft: "Informed Consent Comes Home to Roost" *Australian Health Law Bulletin* Vol 2 #7 April 1994 p.86.
[9] Unreported Botting DCJ., Brisbane District Court, 11.2.1994 No. 1219/92.
[10] Case outline extracted from P. Croft: "Informed Consent Comes Home to Roost", *Australian Health Law Bulletin* Vol 2 #7 p.86-87.
[11] Informed Consent to Medical Treatment, H.D. Sperling Q.C.; NSW branch AMA Seminar 14 April 1991 p.31-32.
[12] See also the NH&MRC's *General Guidelines for Medical Practitioners on Providing Information to Patients.*
[13] Yung C.G. 1966. The Development of Personality, *Complete Works* 2nd edn, Vol 17 pp284-323.
[14] Tobin Q.C. "Implementing Rogers v Whitaker", *What Should Patients Be Told?,* John Plunkett Centre for Ethics, Sydney 1993; Kerridge & Mitchell "Missing the Point: Rogers v Whitaker and The Ethical Ideal of Informed and Shared Decision-making; *Journal of Law & Medicine* Vol 1 No. 4 (May 1994) p.239.
[15] Consent and The Doctor/Patient Relationship; M. Kirby, *Principles of Health Care Ethics,* R. Gillan.

• • • • • • • • • • •

Hospital Board adopts new protocol on CPR

In drawing up the protocol concerning Cardiopulmonary Resuscitation, which was recently adopted by the Board of St Vincent's Hospital in Sydney, the members of the Bioethics Committee at the Hospital were determined not only to get things right clinically, ethically and legally but also to write a one-page document which could be pinned up on a ward noticeboard and read with ease!

The committee began working on this new protocol several years ago, and then put the matter aside pending the publication of promised guidelines on the subject from the New South Wales Department of Health. With the publication of these guidelines (entitled 'Dying with Dignity") last year, the committee returned to the protocol and expected to be able to put the finishing touches to it quite quickly. In fact, many more hours of debate, consultation and deliberation over individual words and phrases went into its preparation. The committee sought the advice of several external clinicians whose generous and patient assistance greatly improved its own efforts.

The resulting document, to be found over the page, reflects the way one particular group of people at one particular teaching hospital understands the issues. It is a document which may be read at several levels. In its brevity, we hope it will appeal to those with no taste for lengthy treatises. In its density we hope that it will serve as a useful educational tool. For into so short a document are packed the range of practical principles - clinical, ethical and legal - in accordance with which good judgments in individual cases will be made.

We publish the protocol in *Bioethics Outlook* in the hope that it will be of some interest, and even of some assistance, to others who would like to draw up their own protocols. The Bioethics Committee welcomes comments on its work.

Cardiopulmonary Resuscitation (CPR)
St Vincent's, Sydney, 1994

1 Introduction:

The expression 'CPR' covers a number of treatment options (endotracheal intubation, cardiac compression, direct current cardioversion, the use of inotropic infusions, etc.).

2 Treatment Decisions:

When cardiopulmonary resuscitation (CPR) is an anticipated treatment option, the senior doctor should normally establish whether, in the event of an arrest, the patient wishes to be resuscitated.

A In the case of a **competent** patient, a directive to withhold or limit resuscitation should be issued and documented after the senior doctor has discussed the matter with the patient and established that the patient judges that the benefits of resuscitation would be disproportionate to the burdens the patient foresees it would impose (except in the rare case where the senior doctor thinks that the patient is suicidal). When a patient expresses a wish to be resuscitated, then the appropriate resuscitative procedures should be undertaken.

B In the case of an **incompetent** patient, a directive to withhold or limit resuscitation should be issued and documented when the senior doctor (having taken into consideration what the family or appropriate caregivers know about what the patient's wishes would have been) judges that the benefits of resuscitation would be disproportionate to the burdens it would impose. If the family or caregivers of an incompetent patient disagree with the doctor's judgment, the doctor should endeavour to persuade them of the reasonableness of his or her judgment (if necessary, calling on the advice of an independent colleague) and then provide what treatment he or she judges to be in the patient's best interests.

In a case in which the senior doctor judges that it would be both medically futile to try to resuscitate the patient (in that it would bring no therapeutic benefit to the patient) and that it would not be appropriate to discuss this with the patient, the doctor's decision to withhold or limit resuscitation should be documented and (normally) communicated to the patient's family and caregivers.

3 Consultation and Information:

In making these decisions, the senior doctor should take into consideration the advice of the senior nurse who, in turn, has the responsibility to communicate them to nursing and allied staff.

4 Documentation:

Any order to withhold or limit resuscitation should be documented, dated and signed clearly and prominently either by the senior doctor or by his or her delegate who records this as the senior doctor's decision. It should include specific reference to treatments to be continued (for example, palliative treatments) and to the limits of resuscitative effort.

5 Treatment Review:

Any treatment decisions concerning resuscitation should be reviewed and documented regularly (at least once a week) and in response to changes in the patient's condition and on the request of a patient or a family.

Bioethics Outlook is a quarterly publication of the John Plunkett Centre for Ethics in Health Care, a Research Centre of Australian Catholic University and St Vincent's Hospital, Sydney.
Telephone 61-2-361 2869 Facsimile 61-2-361 0975
Editor: Bernadette Tobin Layout: Barbara Reen
Subscription is $50 (Institutions), $35 (Individuals) and $15 (Students or Pensioners).
John Plunkett Centre for Ethics in Health Care, St Vincent's Hospital, Victoria Street, Darlinghurst NSW 2010 AUSTRALIA
ISSN 1037-6410