

*WHERE TO FROM CASTELL v DE GREEF? LESSONS FROM RECENT DEVELOPMENTS IN SOUTH AFRICA AND ABROAD REGARDING CONSENT TO TREATMENT AND THE STANDARD OF DISCLOSURE*

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1. INTRODUCTION

The courts have had limited opportunity in the last decade to develop the law concerning consent to surgical procedures.<sup>1</sup> *Castell v de Greef*, a 1994 decision of a Full Bench of the Cape Provincial Division, remains the definitive ruling on the standard of disclosure required for informed consent to medical treatment.<sup>2</sup>

In that case, Ackermann J<sup>3</sup> held that a doctor is under a legal duty to obtain the patient's informed consent to any medical intervention. For consent to be informed, he held, a patient needs to appreciate fully the nature and extent of the harm or risk to which he is consenting.<sup>4</sup> The standard of disclosure requires only material risks to be disclosed. The test to determine if a risk is material is what a reasonable person in the plaintiff's position would have considered significant and thus worth mentioning or what the doctor ought reasonably to have known that the particular patient on whom he was about to operate would consider significant enough to warrant disclosure.<sup>5</sup>

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<sup>1</sup> The context of this paper is limited to non-emergency, invasive medical procedures such as surgery. Its scope is further limited to consent obtained from adult patients capable of making their own decisions (legally competent adults).

<sup>2</sup> 1994 (4) SA 408 (C). Hereafter referred to as *Castell*.

<sup>3</sup> Friedman JP and Farlam J concurring.

<sup>4</sup> *Castell* supra note 2 at 425.

<sup>5</sup> *Castell* supra note 2 at 426. Whether the test for materiality is part of the ratio or obiter is not clear from the judgment. However, in *Broude v McIntosh and others* 1998 (3) SA 60 (SCA) at 68--9 the court appears implicitly to have accepted the test. There has, to date, been no firm judicial pronouncement on the standard of disclosure, although it was applied recently by the Supreme Court of Appeal in *Louwrens v Oldwage* 2006 (2) SA 161 (SCA) at 173. However, the court (at 174) overlooked the test for materiality in *Castell* and approved the dictum in the earlier and possibly overruled case of *Richter and Another v Estate Hanman* 1976 (3) SA 226 (C) at 232, which said that conduct should be measured according to the standard of a reasonable doctor.

The court's rationale for adopting a more patient-focused approach was that this recognized the fundamental rights of autonomy and self-determination towards which South African society was moving.<sup>6</sup>

The subsequent adoption of the Constitution<sup>7</sup> and entrenchment of rights to human dignity<sup>8</sup> and bodily integrity<sup>9</sup> bears out this movement and highlights that South African society is founded on the underlying values of individual autonomy and self-determination. Indeed, s 12(2)(c) of the Constitution expressly requires informed consent for certain medical procedures.<sup>10</sup> The National Patients' Rights Charter, issued in 2001 by the Department of Health, and the National Health Act 61 of 2003 both seek to give effect to these values.

This raises the question whether the *Castell* approach is fully in line with these developments. As neither the Constitutional Court nor the Supreme Court of Appeal has so far been called upon to evaluate the common law relating to consent to medical treatment, there is as yet no definitive answer to this question.

This article analyses the current position, and concludes that the standard of disclosure, being too vague and general in its current formulation, must be rendered more precise by the addition of specific criteria regarding what ought to be disclosed and what qualifies as a material risk. After setting out the common law position post *Castell*, the article analyses foreign case law in order to assess trends in related jurisdictions. This is followed by discussions of the general legal and philosophical principles which underpin this area of law and of the current legislative and policy position in South Africa. Using this to assess the common law as formulated in *Castell*, I argue that while the courts' approach to consent to surgical procedures is in several respects satisfactory as it stands, it nevertheless requires revision in order to give better expression to the constitutional values of autonomy and dignity. In the conclusion I propose how this might be done.

## 2. THE CURRENT SOUTH AFRICAN CASE LAW

In *Castell* the plaintiff consulted the defendant, a plastic surgeon, who advised that she should consider having a mastectomy as a precautionary measure. The operation was not a success and the plaintiff sued successfully for damages. One of the issues was the extent of the surgeon's duty of disclosure when obtaining consent for an operation. The court *quo* stated that '[a] medical practitioner undoubtedly has a duty in certain circumstances to warn his patient of the risks involved in surgery . . .' but that '[t]he difficulty is to determine when that duty arises and what the nature and

<sup>6</sup> *Castell* supra note 2 at 426.

<sup>7</sup> The Constitution of the Republic of South Africa, 1996 (hereafter referred to as 'the Constitution').

<sup>8</sup> Section 10.

<sup>9</sup> Section 12(2).

<sup>10</sup> This provides that: 'Everyone had the right to bodily and psychological integrity, which includes the right not to be subjected to medical or scientific experiments without their informed consent.'

extent of the warning must be'.<sup>11</sup> The view taken by the court a quo was that the conduct of a doctor in relation to both medical diagnosis and treatment should be tested against the standard of the reasonable doctor faced with the same problem.<sup>12</sup> In determining what the reasonable doctor would have done in the circumstances, the court a quo said that it should be guided by medical opinion and medical evidence — but must of course make up its own mind in this regard.<sup>13</sup> Scott J thought that the 'reasonable doctor' test did not leave the determination of a legal duty to the judgement of doctors.<sup>14</sup> It is difficult to see how Scott J reached this conclusion, since a court makes a decision on any matter beyond its expertise on the basis of the testimony of experts within the particular field. Surely the only way a court would 'make up its own mind in this regard' would be to decide which of the experts it found most persuasive? Ackermann J disagreed with the court a quo on this point, saying that the 'reasonable doctor' test left the determination of a duty in the hands of the medical profession, effectively making it a judge in its own cause.<sup>15</sup>

Ackermann J examined the trends in America, Canada, England and Australia regarding the standard of disclosure, and concluded that it was time to shift the focus from a doctor-centred approach to a patient-oriented approach.<sup>16</sup> He stated that 'it is clearly for the patient to decide whether he or she wishes to undergo the operation, *in the exercise of the patient's fundamental right to self-determination*'.<sup>17</sup> Clearly, in terms of South African law, a patient has the right to refuse medical treatment.<sup>18</sup> In *Castell*, Ackermann J used the example of a woman who chose to refuse a total mastectomy even though this was the only way she could avoid dying of cancer.<sup>19</sup> He stated that 'it is, in principle, wholly irrelevant that her attitude is, in the eyes of the entire medical profession, grossly unreasonable, because her rights of bodily integrity and autonomous moral agency entitle her to refuse medical treatment'.<sup>20</sup> This view fits with the idea that truly autonomous decisions concerning healthcare are those in which an individual has been given the opportunity of exercising his subjective freedom to choose one or none of the varying options presented to him and then to take responsibility for that choice.

However, the patient can only be expected to take responsibility for the choice if he or she has sufficient information about the options. The legal standard of disclosure sets out the minimum acceptable levels of practice.

<sup>11</sup> Scott J quoted in *Castell* supra note 2 at 416.

<sup>12</sup> *Ibid* at 418. In coming to this view the court relied on the earlier case of *Richter and Another v Estate Hamman* supra note 5, a decision of a single judge, Watermeyer J.

<sup>13</sup> *Ibid*.

<sup>14</sup> This is the position adopted in *Sidaway v Bethlehem Royal Hospital Governors and others* [1985] 1 All ER 643, the leading English case on the duty of disclosure.

<sup>15</sup> *Castell* supra note 2 at 419–20.

<sup>16</sup> *Ibid* at 420.

<sup>17</sup> *Ibid* (my emphasis).

<sup>18</sup> This right of refusal now also has a statutory basis in s 6(1)(d) of the National Health Act 61 of 2003.

<sup>19</sup> *Castell* supra note 2 at 420–1.

<sup>20</sup> *Ibid* at 421.

According to *Castell*, the minimum acceptable level of consent currently required in South African law is that:

- the consenting party “must have had knowledge and been aware of the nature and extent of the harm or risk”;
- (b) the consenting party “must have appreciated and understood the nature and extent of the harm or risk”;
- (c) the consenting party “must have consented to the harm or assumed the risk”;
- (d) the consent “must be comprehensive, that is extend to the entire transaction, inclusive of its consequences”.<sup>21</sup>

The use of the word ‘comprehensive’ implies that the process of informed consent is an ongoing dialogue between patient and doctor. The informed consent process is not over once a patient has consented to undergo an operation. After the operation the patient must be informed of the relevant post-operative aspects, as well as what is required once he has been discharged from hospital. In a patient-oriented approach this crucial aspect should be incorporated into the consent process.<sup>22</sup>

In terms of *Castell* a doctor need only disclose the *material* risks associated with the proposed treatment. Thus, one could say that for consent to be informed the person giving the consent must know and appreciate the material risks inherent in the proposed treatment.

Whether a risk is material depends on the ‘circumstances of the particular case’, and whether:

- (a) a reasonable person in the patient’s position, if warned of the risk, would be likely to attach a significance to it; or
- (b) 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.’<sup>23</sup>

The difficulty with the second part of this is that the particular patient’s circumstances must be considered and although the medical practitioner may not be aware of them, it is reasonable to expect that he ought to have made inquiries. However, *Castell* gives no further guidance as to how this alternative, more patient-oriented test should be applied.<sup>24</sup> On the face of it, the second leg of the test (‘the particular patient’) appears to give full and proper recognition to the notion of patient autonomy. It appears as if the particular patient’s wishes are to be the paramount consideration.

However, on a careful reading it is evident that even in this apparently subjective inquiry the starting point of the test is the perspective of the doctor rather than that of the particular patient, and that through the use of the words ‘reasonably’ and ‘likely’ the overriding criterion of reasonableness and hence, the reasonable person standard, is maintained.<sup>25</sup> Exactly how a South African court would apply the test is not clear. This is because in *Castell* the

<sup>21</sup> *Ibid* at 425.

<sup>22</sup> This holistic understanding of the informed consent process is echoed by the Health Professions Council of South Africa’s (HPCSA) guidelines — discussed below.

<sup>23</sup> *Ibid* at 426.

<sup>24</sup> In fact, it is difficult to gauge which leg (objective or subjective) of the test the court used in reaching its decision that the undisclosed risk was material.

<sup>25</sup> Ian Kennedy & Andrew Grubb *Medical Law* 3 ed (2000) 700.

court, oddly, did not apply the test it had formulated. Instead the court asked whether the plaintiff would have adopted a different course of action if the risk had been made known to her.<sup>26</sup>

Thus it would appear that the actual test for materiality in terms of the common law is in fact that ‘a risk is material if the person who consented would not have done so had the risk been known to him’.<sup>27</sup> This test, and not the one formulated in *Castell*, was subsequently applied by the Supreme Court of Appeal in *Broude v McIntosh*.<sup>28</sup>

Even the most recent Supreme Court of Appeal judgment in *Louwrens v Oldwage*<sup>29</sup> did not apply the test formulated in *Castell* but rather relied on the ‘reasonable doctor’ test set out in the 1976 case of *Richter and another v Estate Hamman*,<sup>30</sup> which was very explicitly criticized — even possibly overruled — in *Castell*. On the basis of this test the court reversed the decision of the lower court, in which Yekiso J, applying an extended version of material risk test, found that there had been no informed consent. He had stated that the ‘consent . . . will only be “informed” if it is based on substantial knowledge concerning the nature and the effect of the act consented to’,<sup>31</sup> substantial knowledge being knowledge of ‘the material risks and consequences which may ensue during and consequent to the proposed treatment’.<sup>32</sup>

In discussing the doctor’s duty of disclosure, Yekiso J referred to the recent English case of *Chester v Afshar*<sup>33</sup> and stated that ‘the object [of informing the patient as to the risks and dangers of the treatment] is to enable the patient to decide whether or not to run the risk of consenting to the [proposed] treatment’.<sup>34</sup> The learned judge commented that he was ‘bound to follow [the approach in *Castell*] unless . . . it [was] clearly wrong, which’, he said, ‘it was not’.<sup>35</sup> On the facts the court held there was no informed consent. It is submitted that Yekiso J nevertheless in fact made a slight addition to the requirements for valid consent when he expressly recognized that proper disclosure requires not only that the material risks be disclosed but also that the available alternatives to the proposed treatment be presented to the patient.<sup>36</sup> On appeal, however, this approach was not followed.

An important aspect of the relationship between the requirement of consent and the Constitution’s focus on dignity and autonomy concerns the manner in which the absence of consent is conceptualized. The traditional way to plead lack of consent to treatment is to claim that an assault took place. Although a surgical intervention can be described as involving the

<sup>26</sup> *Castell* supra note 2 at 130: ‘There is no convincing evidence that she would have adopted a different course nor, if she had, that a materially better result would have ensued.’

<sup>27</sup> Anton Fagan *The Iniuria of Assault* unpublished manuscript (16 February 2006) 29.

<sup>28</sup> Supra note 5.

<sup>29</sup> Supra note 5, judgment by Mthiyane JA. Mpati DP, Streicher, Lewis and Ponnann JJA concurred.

<sup>30</sup> Supra note 5, a single-judge decision.

<sup>31</sup> *Ibid.*

<sup>32</sup> *Ibid.*

<sup>33</sup> [2002] 3 All ER 552 at 572.

<sup>34</sup> *Oldwage v Louwrens* [2004] 1 All SA 532 (C) para 89.

<sup>35</sup> *Ibid.*

<sup>36</sup> *Ibid* para 96.

exercise of force, there is case authority endorsing the view that a person may commit the iniuria of assault merely by interfering or attempting to interfere with the body of another.<sup>37</sup> As such, where an assault has been committed without force and without insult, the courts have in some instances awarded damages.<sup>38</sup> Although a physical injury was suffered by the plaintiff in all the cases that have come before the South African courts on the issue of consent to medical treatment, with most pleaded in terms of an assault,<sup>39</sup> physical injury is not a requirement for an infringement of corpus — the mere infringement of the right is sufficient to constitute harm.<sup>40</sup> There also need not be a sense of insult (contumelia) accompanying the physical assault, which on its own is enough to found a cause of action.<sup>41</sup>

This appears to fit well with the constitutional protection of dignity and autonomy. Not disclosing a material risk is an inroad into the patient's right to make informed decisions about what will and will not be done to his body. That is, it is an infringement of his or her dignity and autonomy, and actual injury and the exercise of physical force are not required.

In its recent decision in *Broude v McIntosh*, however, the Supreme Court of Appeal regarded this way of pleading as conceptually odd and stated that it merited re-examination when the appropriate case arose.<sup>42</sup> The court considered it 'bizarre' that in a situation where the undisclosed risk did not eventuate and the operation was a success a doctor might nevertheless be found guilty of an assault.<sup>43</sup> Endorsing the judgment, Van der Walt and Midgley observe that '[a]n assault occurs where it is intended to cause bodily injury unlawfully, and instances where harm is not intended should not be categorised in this way'.<sup>44</sup> They point out that the terminology of assault can be avoided by rather pleading an intentional or negligent infringement of the right to bodily integrity (corpus).<sup>45</sup> As long as it is clearly understood that physical injury is not a requirement in South African law, this would still cohere with the Constitution's emphasis on dignity and autonomy, and may indeed do so more clearly than the current practise. Regrettably, the Supreme Court of Appeal failed to use the opportunity it recently had in

<sup>37</sup> See *Stoffberg v Elliot* 1923 CPD 148 at 148 and *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T), cited in Fagan op cit note 27 at 5.

<sup>38</sup> *Stoffberg v Elliot* supra note 37 at 152. See also *Manamela v Minister of Justice and Others* 1960 (2) SA 395 (A) where the court awarded exemplary damages for an assault.

<sup>39</sup> *Stoffberg v Elliott* supra note 37; *Esterhuizen v Administrator, Transvaal* supra note 37; *Castell v de Greef* supra note 2; *Broude v McIntosh* supra note 5; *Lourens v Oldwage* supra note 5.

<sup>40</sup> J R Midgley & J C van der Walt 'Delict' in W A Joubert (ed) *The Law of South Africa* vol 8(1) First Reissue para 40.

<sup>41</sup> J C van der Walt & J R Midgley, *Principles of Delict* 3 ed (2005) para 78.

<sup>42</sup> *Broude v McIntosh* supra note 5 at 67--8.

<sup>43</sup> *Ibid* at 68.

<sup>44</sup> Van der Walt & Midgley op cit note 41 para 78.

<sup>45</sup> *Ibid*.

*Louwrens v Oldwage*<sup>46</sup> to re-examine this apparent anomaly when the alleged lack of informed consent was again pleaded as an assault.<sup>47</sup>

### 3. CASTELL IN CONTEXT

The doctrine of informed consent originated in the USA in the 1950s<sup>48</sup> and '60s from where it, or something similar,<sup>49</sup> spread to Canada in 1981 (*Reibl v Hughes*<sup>50</sup>), Australia in 1992 (*Rogers v Whitaker*<sup>51</sup>), South Africa in 1994 (*Castell v de Greef*<sup>52</sup>) and lastly to England in 1999 (*Pearce v United Bristol Health care NHS Trust*<sup>53</sup>). How does the position in South African law outlined in the previous section of this article compare with the operation of this doctrine in these foreign jurisdictions? Does it provide at least the same degree of protection for patients' dignity and autonomy?

These questions are important in their own right, but they are given added urgency by the fact that there has not yet been a definitive pronouncement on the impact of the relevant constitutional provisions on consent to medical procedures. Here, as in other contexts, comparative legal analysis has much to offer, and this article therefore now turns to an examination of developments in these jurisdictions. But comparative analysis is not sufficient; it is equally necessary to consider the nature and purpose of the consent requirement, and to examine its treatment in South African legislation and policy. For that reason the survey of foreign law is followed by discussions of the philosophical basis of the notion of informed consent and of its implementation in legislative and other official instruments.

#### 3.1 *The case law of other Commonwealth jurisdictions*

##### 3.1.1 *Canada*

Informed consent is well-known in Canadian jurisprudence. The Canadian duty of disclosure requires not just disclosure of the material risks but also of 'any special or unusual risks',<sup>54</sup> and a risk with serious consequences, such as death or paralysis, should always be disclosed, even if the chance of it occurring were slight.<sup>55</sup> The courts also recognize that subjective considerations may creep into assessments of this kind.

In the recent case of *Amdt v Smith*,<sup>56</sup> Cory J approved of the material risk

<sup>46</sup> *Supra* note 5.

<sup>47</sup> *Ibid* at 164 where the court stated that one of issues on appeal was 'whether the plaintiff gave informed consent to the surgical procedure performed by the defendant, in the absence of which consent such intervention would have amounted to an assault'.

<sup>48</sup> The term 'informed consent' was first introduced in *Salgo v Leland Stanford Junior University Board of Trustees* 317 P 2d 170 (Cal 1957).

<sup>49</sup> None of the Commonwealth countries have wholly adopted the 'doctrine'.

<sup>50</sup> [1980] 2 SCR 880.

<sup>51</sup> [1992] 109 ALR 625.

<sup>52</sup> *Supra* note 2.

<sup>53</sup> (1999) 48 BMLR 18 (CA).

<sup>54</sup> *Hopp v Lepp* [1980] 2 SCR 192 at 210 per Laskin CJ for the majority.

<sup>55</sup> *Ibid* at 209--10.

<sup>56</sup> 1997 Carswell BC 1260.

test<sup>57</sup> but stated that ‘any “particular concerns” . . . and any “special considerations affecting the particular patient” must be considered’ when determining whether the duty of disclosure has been breached.<sup>58</sup> In determining a material risk a court will inevitably have to consult the relevant medical experts, especially in order to establish the risks of the treatment, the consequences of leaving the illness untreated, alternative means of treatment and their risks and the cause of the injury suffered by the patient,<sup>59</sup> but Canadian courts have always held that ultimately the decision whether a risk is material is a question of law answered by the court.<sup>60</sup>

In *Arndt*, Cory J (for the majority), commenting on the material risk test, said that ‘[i]t marks the rejection of the paternalistic approach to determining how much information should be given to patients. It emphasizes the patient’s right to know and ensures that patients will have the benefit of a high standard of disclosure’.<sup>61</sup> However, the court would not go as far as allowing a purely subjective test and stated that:

‘A purely subjective test could serve as an incitement for a disappointed patient to bring an action. The plaintiff will invariably state with all the confidence of hindsight and with all the enthusiasm of one contemplating an award of damages that consent would never have been given if the disclosure required by an idiosyncratic belief had been made. This would create an unfairness that cannot be accepted. It would bring inequitable and unnecessary pressure to bear upon the overburdened medical profession. On the other hand, a purely objective test which would set the standard by a reasonable person without the reasonable fears, concerns and circumstances of the particular plaintiff would unduly favour the medical profession. . . . The modified objective test serves to eliminate from consideration the honestly held but idiosyncratic and unreasonable or irrational beliefs of patients. The *Reibl* test is fair . . . No useful purpose would be served by changing it.’<sup>62</sup>

The very nature of court proceedings is that a just decision requires a judge to consider the reasonableness of the plaintiff’s claim and to make a reasonable assessment of the cogency and validity of the subjective considerations or idiosyncrasies that might have been advanced by the particular plaintiff. However, it is submitted that in cases concerning the exercise of autonomy, that is, those decisions concerning the body and what will be done to it, a court needs to consider more than just the law. It is the court’s task to carry out a ‘delicate balancing of overlapping personal, ethical, and medical considerations which can lead to more than one “reasonable” choice’.<sup>63</sup>

<sup>57</sup> Confirmed in *Reibl v Hughes* supra note 50.

<sup>58</sup> *Ibid* para 6: ‘The trier of fact must take into consideration any “particular concerns” of the patient and any “special considerations affecting the particular patient” in determining whether the patient would have refused treatment if given all the information about the possible risks.’

<sup>59</sup> See *Canterbury v Spence* (1972) 464 F 2d 772 at 791--2 and *Reibl* supra note 50 at 894.

<sup>60</sup> See *F v R* (1983) 33 SASR 189 at 194.

<sup>61</sup> *Supra* note 56 para 15.

<sup>62</sup> *Ibid* paras 16--17.

<sup>63</sup> *Ibid* para 67 per McLachlin J.

### 3.1.2 *Australia*

The leading Australian case on doctors' duty of disclosure is *Rogers v Whitaker*.<sup>64</sup> The *Rogers* test was incorporated verbatim into South African law by *Castell*. Two readings of this test have been suggested,<sup>65</sup> the one subjective and the other objective: '[O]n one reading, the court could be said to have gone further and endorsed, albeit elliptically, the "particular patient" test', but, depending upon how one reads the word 'or', an alternative reading could be 'that the court is merely stating "the reasonable patient test" in alternative forms'.<sup>66</sup>

If one considers that informed consent is premised on autonomy, it is highly likely, in view of the court's use of the overriding criterion of reasonableness, as well as its deference to the therapeutic privilege, that the second reading is the more plausible one. Although the test for disclosure in Australia and South Africa might appear to be subjective, it is in fact based on the purely objective notion of reasonableness.

That the whole adequate disclosure inquiry is grounded in reasonableness rather than what is considered acceptable medical practice allows the court to assess whether, in the circumstances, the legal duty which a doctor owes to his patient has in fact been met. Added to this, each case must be determined according to its particular circumstances and as a result a court may, in determining the needs of the particular patient, allow subjective considerations to influence its finding. Infusing each inquiry must be the purpose of disclosure, which is 'to provide the patient with the information necessary to enable him to make informed decisions concerning his future and, in particular, whether to undergo proposed treatment'.<sup>67</sup>

In the recent case of *Chappel v Hart*,<sup>68</sup> an undisclosed risk eventuated. The operation itself was carried out without negligence. The plaintiff argued that Dr Chappel had breached the duty of disclosure as set out in the *Rogers* case. She claimed that, if informed of the risk, she would not have consented to have the operation when she did, would have sought a second opinion, and would have had the operation carried out by a more experienced surgeon at a later date. The court accepted these arguments and accepted the test in *Rogers*, with the result that to date this remains the accepted standard of disclosure in Australia.<sup>69</sup>

Addressing the issue of causation, the court made some obiter comments related to the duty of disclosure. Kirby J adopted a subjective test, asking whether the particular patient (that is, the plaintiff), if warned of the risk,

<sup>64</sup> Supra note 51.

<sup>65</sup> Kennedy & Grubb op cit note 25 at 700.

<sup>66</sup> Ibid.

<sup>67</sup> *F v R* supra note 60 at 192.

<sup>68</sup> (1998) 156 ALR 517.

<sup>69</sup> Ibid paras 57 and 65. The five judges (Gaudron, McHugh, Gummow, Kirby and Hayne JJ) sitting in the Australian High Court had to decide whether she could recover damages for her injuries. The primary issue before the court was one of legal causation or remoteness, but that is not the focus of this article.

would have been likely to attach significance thereto.<sup>70</sup> He also noted that ‘the requirement to warn patients about the risks of medical procedures is an important one conducive to respect for the integrity of the patient and better health care’.<sup>71</sup> He noted further ‘the duty which all health care professionals must observe: the duty of informing patients about risks, answering their questions candidly and respecting their rights, including (where they so choose) to postpone medical procedures and to go elsewhere for treatment’.<sup>72</sup> The court held the defendant liable because he had failed to disclose the risk and she had therefore not had the chance to decide whether to postpone the treatment or obtain a second opinion. Interestingly, this approach is similar to that taken by the court in *Castell*, where, rather than applying the *Rogers* test that it endorsed, the court asked whether the plaintiff would have adopted a different course of action if the risk had been made known to her.

In *Rosenberg v Percival*<sup>73</sup> the court examined both materiality and causation<sup>74</sup> and confirmed its previous position in *Rogers*. In his judgment Kirby J, well-known to be a strong supporter of *Rogers*, stated that ‘the rule established . . . in *Rogers* is undoubtedly a strict one’.<sup>75</sup> The learned judge examined the arguments against such an approach to the duty of disclosure<sup>76</sup> and stated that ‘reasons of principle and policy support the stringency of [the disclosure] rule’. The reasons given are, first, that the rule recognizes that autonomy ‘is to be viewed in the wider context of an emerging appreciation of basic human rights and human dignity [and that t]here is no reason to diminish the law’s insistence . . . upon prior informed agreement to invasive treatment’;<sup>77</sup> secondly, that the law demands ‘a recognition that sometimes defects of communication demand the imposition of minimum legal obligations so that even those providers who are in a hurry, or who may have comparatively less skill or inclination for communication, are obliged to pause and provide warnings’; thirdly, that the standard reduces ‘the risks of conflicts of interest and duty which a provider may sometimes face in favouring one health care procedure over another’;<sup>78</sup> fourthly, that requiring a medical practitioner to warn the patient of the material risks evens out the balance of power between him and his patient; and finally, that rigorous legal standards can bring about a change in practice.<sup>79</sup>

A slightly different and more critical approach, however, was taken in the

<sup>70</sup> *Chappel* supra note 68 at 551 para 96.

<sup>71</sup> *Ibid* at 547 para 92.6.

<sup>72</sup> *Ibid* at 550 para 95.

<sup>73</sup> [2001] 178 ALR 577. The case was decided by five judges (Gleeson CJ, McHugh, Gummow, Kirby and Callinan JJ) who, delivering separate judgments, all allowed the appeal.

<sup>74</sup> *Rogers* turned only on materiality and *Chappel* only on causation.

<sup>75</sup> *Rosenberg v Percival* supra note 73 at 609 para 140.

<sup>76</sup> *Ibid* at 610--11.

<sup>77</sup> *Ibid* at 612--13 para 145.

<sup>78</sup> *Ibid*.

<sup>79</sup> *Ibid*.

judgments of Gummow J<sup>80</sup> and Callinan J.<sup>81</sup> Both judges stressed the overriding importance of reasonableness when assessing a doctor's obligations to disclose a risk.<sup>82</sup> These judgments can, and have been, relied on for the proposition that 'in Australia, there is evidence of judicial dilution of the *Rogers* test and the pendulum swinging back towards . . . [a more conservative approach] and greater deference being shown again to the medical profession'.<sup>83</sup>

### 3.1.3 *England*

In the late 1980s the English courts tended to favour a narrow, more conservative, approach to the standard of disclosure. However, in the 1990s judicial opinion began to embrace a broader patient-focused standard. This shifting focus led to a version of the 'reasonable patient' test being adopted into English law in *Pearce v United Bristol Health Care NHS Trust*.<sup>84</sup> In that case, Lord Woolf held that a doctor should normally inform a patient 'of a significant risk which would affect the judgment of a reasonable patient . . . if the information is needed so that the patient can determine for himself or herself as to what course he or she would adopt'.<sup>85</sup> The *Pearce* formulation reflects the current orthodox position in English law.<sup>86</sup>

Slightly before *Pearce*, in *Bolitho v City and Hackney Health Authority*,<sup>87</sup> the House of Lords glossed the *Bolam* test for medical negligence,<sup>88</sup> in its application to medical treatment and diagnosis, by requiring that the relevant prevailing medical opinion must be rational and capable of withstanding logical analysis. Some commentators took the view that the same test must apply also, or perhaps a fortiori, to the doctor's duty to disclose information

<sup>80</sup> Ibid at 593 paras 67--9, observing that one of the relevant (but not decisive) factors when determining the material risk that a reasonable doctor should have foreseen was 'the state of medical knowledge at the time when the duty should have been performed. A reasonable medical practitioner cannot be expected to have foreseen an event wholly uncomprehended by medical knowledge at the time. This reflects the fundamental proposition that the law demands no more than what was reasonable in all the circumstances of the case.'

<sup>81</sup> Ibid at 631 para 219, noting that: 'With the growth in scientific awareness by informed people of ordinary imaginative power, it will almost always be possible to say, after an event that it was foreseeable. It should be kept in mind that the word "reasonably" has real work to do in testing whether an event was foreseeable. So too, what is required to establish negligence is a want of reasonable care and skill. In testing whether they are lacking, the word "reasonable" again has real work to do. Neither professionals nor other providers of services should have too onerous obligations of foresight or care and skill imposed upon them.'

<sup>82</sup> Ibid at 593 para 67.

<sup>83</sup> Joanna Manning 'Informed consent to medical treatment: The common law and New Zealand's code of patients' rights' (2004) 12 *Medical Law Review* 181 at 189. This point was brought to my attention by N Whitty.

<sup>84</sup> Supra note 53.

<sup>85</sup> Ibid at 124.

<sup>86</sup> See Kennedy & Grubb op cit note 25 at 708--9; Margaret Brazier *Medicine, Patients and the Law* 3 ed (2003) at 107--8; J K Mason and G T Laurie *Mason and McCall Smith's Law and Medical Ethics* 7 ed (2005) at §§ 10.130--10.131. This was brought to my attention by N Whitty.

<sup>87</sup> [1998] AC 232 (HL).

<sup>88</sup> 'A medical practitioner is not negligent, if he is acting in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, merely because there is a body of such opinion that takes a contrary view.' This test was confirmed by the majority in *Sidaway* supra note 14.

about medical risks since the duty of disclosure raises questions that judges can assess much more easily than questions of diagnosis or treatment.<sup>89</sup>

*Peace* was applied by the House of Lords in the recent case of *Chester v Afshar*,<sup>90</sup> which relied on *Chappel v Hart*,<sup>91</sup> an Australian decision. The facts were that Ms Chester, a journalist, suffered from severe long-term back pain. She was advised to consider surgical intervention. Ms Chester informed her doctor that for her surgery was a last resort and that she wanted to investigate alternative treatment methods. She was referred to a neurosurgeon, the defendant, who advised surgery. The surgery was elective rather than emergency treatment. Under pressure from the defendant to have surgery, she followed his advice. One of the small, but unavoidable risks of the surgery was paralysis or confinement to a wheelchair.<sup>92</sup> The court accepted that Dr Afshar had failed to advise Ms Chester of this risk. He did not suggest any possible alternatives (and there were alternatives to surgery) or offer her the opportunity to seek a second opinion.

The claim before the court was twofold. It concerned both the failure to disclose the risks associated with the operation and the conduct of the operation. Although the court found that the defendant had not been negligent in conducting the operation, the operation was far from a success, as Ms Chester could not move on regaining consciousness, nor did she have normal sensation. A second operation was carried out to find the cause of the impairment. This operation showed that the cause of the paralysis was due to the occurrence of the undisclosed risk.

Examining the duty to warn, the Court of Appeal applied the *Bolam* principle, as confirmed in the 1980s case of *Sidaway*.<sup>93</sup> The court also examined the Australian position regarding disclosure set out in *Rogers v Whitaker*<sup>94</sup> and stated that: 'These standards have fairly been described as onerous. They are. But they are the law. They are established for good reason. When not complied with it should occasion no surprise that legal consequences follow.'<sup>95</sup>

The court conceded that 'English law does not impose quite such a rigorous standard upon doctors as that in *Rogers*', but stated that 'the policy point' made by Kirby J in *Chappel* would still apply.<sup>96</sup> The policy point was that imposing liability was merely the result of 'the duty which all health care professionals . . . must observe: the duty of informing patients about risks, answering their questions candidly and respecting their rights, including

<sup>89</sup> See the important article by M Brazier & J Miola 'Bye-bye *Bolam*: A medical revolution' (2000) 8 *Medical Law Review* 85 at 108. In fact, in *Peace*, Lord Woolf referred with approval to *Bolitho*. This was brought to my attention by N Whitty.

<sup>90</sup> *Supra* note 33.

<sup>91</sup> *Supra* note 68.

<sup>92</sup> There was a 1 to 2 per cent risk of 'cauda equina syndrome'.

<sup>93</sup> See note 88.

<sup>94</sup> *Supra* note 51.

<sup>95</sup> *Supra* note 33 at 568 para 33.

<sup>96</sup> *Ibid* para 34.

(where they so choose) to postpone medical procedures and to go elsewhere for treatment'.<sup>97</sup> The court commented that:

'[A] patient . . . ha[s] the right to choose what will and will not be done with her body and the doctor must take the care expected of a reasonable doctor in the circumstances in giving her the information relevant to that choice. The law is designed to require doctors properly to inform their patients of the risks attendant on their treatment and to answer questions put to them as to that treatment and its dangers, such answers to be judged in the context of good professional practice, which has tended to a greater degree of frankness over the years, with more respect being given to patient autonomy. The object is to enable the patient to decide whether or not to run the risks of having that operation at that time.'<sup>98</sup>

*Chester* did in fact take the English position a bit further. The court gave due recognition to patient autonomy and to what it aims to protect; that is, the right of the patient to decide for himself what will or will not be done to his body. The House of Lords<sup>99</sup> confirmed the decision of the Court of Appeal, but made some additional noteworthy comments regarding the duty of disclosure, the most significant of which is that the court, not the medical profession, is the final arbiter of what constitutes informed consent.<sup>100</sup>

In his majority judgment, Lord Steyn noted a number of relevant factors that should be considered in the context of disclosure. First, when assessing the rights and correlative duties of the patient and the surgeon, the starting point is always patient autonomy, in the sense that 'every individual of adult years and sound mind has a right to decide what may or may not be done with his or her body' and that even a decision which a medical practitioner regards as 'ill-advised' should be respected, because '[i]n modern law medical paternalism no longer rules and a patient has a prima facie right to be informed by a surgeon of a small, but well established, risk of serious injury as a result of surgery'.<sup>101</sup> Secondly, he noted that all rights are not equally important but that 'a patient's right to an appropriate warning . . . must be given effective protection wherever possible'.<sup>102</sup> Thirdly, the rule requiring a medical practitioner to obtain informed consent from patient serves two purposes. Those purposes are that it avoids the occurrence of an injury for which the patient is not prepared and it respects the autonomy and dignity of each patient.<sup>103</sup>

In fact, the majority gave such substantial weight to autonomy and dignity that the court saw fit to depart from the traditional principles of causation because, as Lord Steyn noted, 'it is the aspiration of the law to right wrongs', and in the view of the majority, Ms Chester had suffered a wrong in that she was not warned of the risk and thus was not able to obtain a second, or third, opinion or to postpone the operation to a future date.<sup>104</sup> Lord Hope put it this way: 'The law which imposed the duty to warn on the doctor has at its

<sup>97</sup> *Ibid* para 33.

<sup>98</sup> *Ibid* at 572 para 47.

<sup>99</sup> [2004] 4 All ER 587.

<sup>100</sup> *Ibid* at 593 para 14.

<sup>101</sup> *Ibid* at 594 para 16.

<sup>102</sup> *Ibid* at 594 para 17.

<sup>103</sup> *Ibid* at 594 para 18.

<sup>104</sup> *Ibid* at 597 para 25.

heart the right of the patient to make an informed choice as to whether, and if so when and by whom, to be operated on.<sup>105</sup> Although he did not embrace a subjective patient-oriented standard, he recognized that '[a]ll sorts of factors may be at work' when a patient makes his decision to undergo surgery, such as 'the patient's hopes and fears and personal circumstances, the nature of the condition that has to be treated and, above all, the patient's own views about whether the risk is worth running for the benefits that may come if the operation is carried out'.<sup>106</sup> Lord Walker, in his majority judgment, noted that in the 20 years that had passed since *Sidaway*, 'the importance of personal autonomy has been more and more widely recognised' and agreed with Lords Steyn and Hope that on policy grounds the plaintiff should succeed because to disallow the claim of a patient who had suffered an injury directly within the scope and focus of the duty would have the effect of draining it of its content.

Although the House of Lords did not change the legal standard of disclosure it did make a decision based on what it believed to be considerations of fairness and justice and a 'reflection of the reasonable expectations of the public in contemporary society'. All the judges also recognized and accepted the overriding importance of personal autonomy but they did not actually go as far as embracing a purely subjective standard.<sup>107</sup>

However, while commentators generally approve of the court's vindication of a patient's right to dignity, autonomy and self-determination, the *Chester* decision has been criticized, because rather than extending the standard of disclosure, it bent the rules of causation so that an award of damages could be made. The Australian case of *Chappel* did the same.

#### 3.1.4 Synthesis

In one respect South Africa comes out best in a comparison with these three jurisdictions. In granting compensation (in the form of a solatium) by way of the *actio iniuriarum* for the infringement of the right to bodily integrity, irrespective of whether plaintiff suffered physical harm, South African law provides direct protection to individual autonomy. In *Chester* the House of Lords considered this possibility, but it was rejected by Lord Hoffmann: he could see that there might be a case for a modest solatium in such cases, but thought that the risks will vary greatly in severity, there would be great difficulty in fixing a suitable figure, and the cost of litigation would make tort law an unsuitable vehicle for distributing the modest compensation which

<sup>105</sup> *Ibid* at 612 para 86.

<sup>106</sup> *Ibid*.

<sup>107</sup> See K Mason & D Brodie 'Bolam, Bolam — Wherefore art thou Bolam?' (2005) 9 *Edinburgh Law Review* 298.

might be payable. These concerns are less cogent than they might appear, however.<sup>108</sup> As Waddam points out:

'If the object is to reinforce the physician's duty to disclose, would it not be better to approach that object frankly and directly by recognition of an award for the intangible loss of autonomy and dignity? Compensation would then be measured by the interests really affected, and there would be no need to resort to tenuous causation arguments in order to mark the court's disapproval of the physician's conduct. Moreover, compensation could then be awarded for failure to disclose even if no damage materialised. If the sums awarded were moderate it is likely that the medical profession and its insurers would also welcome this approach, which would be predictable, would facilitate settlements, and would distinguish plainly between negligence in the consulting room and negligence in the operating room.'<sup>109</sup>

The availability of a solatium under the *actio iniuriarum* enables the courts to respect the patient's right to autonomy and dignity without having to bend the rules.<sup>110</sup> This is especially important where the undisclosed risk has failed to materialize. Non-disclosure of a risk may be material to a patient regardless of whether it ultimately eventuates, as it limits his ability to make an informed choice, that is, his ability to consider all the available choices, and then to accept one or reject all. If the consent is to be comprehensive, then the fact that there is a less intrusive or less risky alternative procedure available or that the operation is not an 'emergency' but something that can be postponed ought to be disclosed. Otherwise, the patient's autonomy and self-determination are infringed. In this context the protection afforded by the *actio iniuriarum* to personality rights is vitally important and must not be lost sight of.

But in other respects South African law has much to learn from these three jurisdictions. They show that there is a need to expand the scope of the doctor's duty of disclosure as formulated in *Castell* and, in particular, to guard against a return to the older 'reasonable doctor' test. In *Chester* the court recognized that autonomy means answering patients' questions candidly and respecting their rights, including, in the case of elective and non-emergency surgery, the right to choose to postpone medical procedures and to go elsewhere for treatment. This is an implicit recognition of the need to present the options available, not just the doctor's recommended course of action. If the patient chooses an option, which the doctor thinks is ill-advised because the choice is based on avoiding a small, but well-established risk, he

<sup>108</sup> See note 38 regarding exemplary damages. Also see also *Rees v Darlington Memorial NHS Trust* [2003] 4 All ER 987 para 6, discussed in Mason & Brodie op cit note 107. This point was brought to my attention by N Whitty.

<sup>109</sup> S M Waddams 'Causation, physicians and disclosure of risks' 1999 *Tort Law Review* 5. This was brought to my attention by N Whitty.

<sup>110</sup> An example can be found in a recent case decided in Scotland, a mixed legal system like South Africa. In *Goorkani v Tayside Health Board* 1991 SLT 94 OH, a man who had lost the sight in one eye through Behcet's disease was given drug therapy to prevent blindness in the other eye. The doctor failed to warn him of the risk of infertility as a side-effect of the drug (Chlorambucil). The pursuer became infertile. It was held on the evidence that if the pursuer had known of the risk, he would have been prepared to accept the risk of infertility for the sake of saving his sight by continuation with the course of treatment with the drug. Nevertheless the Lord Ordinary (Lord Cameron of Lochbroom) awarded a sum of £2,500 for the loss of self esteem, the shock and anger at the discovery of his infertility together with the frustration and disruption which ignorance and the sudden shock of discovery brought to the marital relationship. This was brought to my attention by N Whitty.

must nevertheless respect that choice. The right to autonomy means that a patient can decide whether, when and by whom he wishes to be operated on. The Australian case of *Percival* recognizes that obligations are imposed on doctors so that even those who are in a hurry, or who may have comparatively less skill or inclination for communication, are obliged to pause and provide warnings, and to ensure that all options are presented rather than just those towards which the health professional is himself inclined. From the Canadian jurisprudence two factors can be added. They are the importance of the particular concerns of the individual patient and any special considerations affecting him or her.

Canadian courts have embraced subjective considerations and have examined the patient's 'particular concerns' and 'special considerations'.<sup>111</sup> Australian decisions looked at the particular patient's concerns and used autonomy as a starting point, while recent English judgments indicate a general hesitancy on the part of the courts to develop the test for adequate disclosure to include subjective considerations. Both England and Australia have recognized the patient's right to information but what must be disclosed has in most cases been determined purely objectively rather than subjectively. The reasons given against adopting a purely subjective standard are that doing so might open the proverbial flood-gates, place too heavy a burden on doctors, require doctors to second-guess patients and the difficulty of quantifying these types of claims. But Canadian experience suggests that these fears are misplaced.<sup>112</sup>

### 3.2 Consent and autonomy

Most discussions surrounding the ethics of medical treatment, and more specifically the doctor-patient relationship, begin with making reference to autonomy. The preamble to the World Medical Association Declaration on the Rights of the Patient, for example, states that a physician should make an 'effort . . . to guarantee patient autonomy'.<sup>113</sup> This begs the question: 'What is autonomy?'

Autonomy forms the foundation of informed consent. As part of the right to self-determination, autonomy generally involves having the freedom to exercise one's personal choice regardless of whether others approve of the choice made. In the context of healthcare, autonomy means that every adult of sound mind has the right to determine what shall or shall not be done to his body.<sup>114</sup> Although the right to self-determination gives a patient the right

<sup>111</sup> *Arndt v Smith* supra note 56 para 6.

<sup>112</sup> Kennedy & Grubb op cit note 25 at 700--1, quoting a study of informed consent cases, point out that: 'There is no evidence in Canada that following *Reibl* the floodgates opened and the courts were swamped with cases alleging breaches of a medical practitioner's duty to disclose. . . . Thus, although the importance of the legal development in *Reibl* and *Rogers* cannot be overstated its effect on litigation (rather than on the practice of medicine) is minimal.'

<sup>113</sup> Adopted by the 34th World Medical Assembly Lisbon, Portugal, September/October 1981 and amended by the 47th General Assembly Bali, Indonesia, September 1995.

<sup>114</sup> *Schloendorff v Society of New York Hospital* (1914) 105 NE 92 per Cardozo J.

to choose whatever course of action he wishes, including the right to refuse medical treatment,<sup>115</sup> it does not normally give a patient the right to demand a particular form of treatment.<sup>116</sup>

Autonomy is often equated with, or seen as flowing from, the values of dignity, integrity, individuality, independence, responsibility and self-knowledge.<sup>117</sup> An autonomous self is independent and self-determining.<sup>118</sup> Ronald Dworkin argues that the value of autonomy ‘derives from the capacity it protects: the capacity to express one’s own character — values, commitments, convictions . . . — in the life one leads.’<sup>119</sup> He states further that autonomy,

‘allows each of us to be responsible for shaping our lives according to our own coherent or incoherent — but, in any case, distinctive — personality. It allows us to lead our lives rather than be led along them, so that each of us can be, to the extent a scheme of rights can make this possible, what we have made of ourselves. We allow someone to choose death over radical amputation or a blood transfusion, if that is his informed wish, because we acknowledge his right to a life structured by his own values.’<sup>120</sup>

However, the truly independent and self-determining self is a theoretical construct. This is because in practise we live in a society of imposed laws and social conditioning.<sup>121</sup> But, the idea of ‘self-determining’ persons is useful in that as self-aware individuals we do have the freedom and ability to make conscious rational choices, even though those choices might be influenced by what is legally and morally<sup>122</sup> permissible. True personal autonomy, argues Joseph Raz, is an ideal in which ‘people control . . . , to some degree, their own destiny, fashioning it through successive decisions throughout their lives’.<sup>123</sup> This is especially pertinent in the area of healthcare because we cannot control every medical eventuality that happens to us, nor can we know the exact outcome of all possible treatment options.

Raz argues that ‘to be autonomous a person must not only be given a choice but he must be given an adequate range of choices’.<sup>124</sup> Thus ‘[a]utonomy is opposed to a life of coerced choices. It contrasts with a life of no choices, or of drifting through life without ever exercising one’s capacity to choose.’<sup>125</sup> Our lives are full of choices freely made and we make decisions

<sup>115</sup> In *Castell* supra note 2 at 421 the court states that: ‘It is, in principle, wholly irrelevant that her . . . [refusal] is, in the eyes of the entire medical profession, grossly unreasonable.’

<sup>116</sup> This issue was decided recently at appellate level in England. See *R (on the application of Burke) v General Medical Council* [2005] 3 WLR 1132 (CA), reversing the decision of the court a quo, which was criticised by J K Mason & G T Laurie ‘Personal autonomy and the right to treatment: A note on *R (on the application of Burke) v General Medical Council* (2005) 9 *Edinburgh Law Review* 123. This point was brought to my attention by N Whitty.

<sup>117</sup> Gerald Dworkin *The Theory and Practice of Autonomy* (1988) 6. Dignity lies at the very heart of South African society — see O’Regan J in *S v Makwanyane and Another* 1995 (3) SA 391 (CC) para 328: ‘The importance of dignity as a founding value of the . . . Constitution cannot be overemphasised. Recognising a right to dignity is an acknowledgement of the intrinsic worth of human beings: human beings are entitled to be treated as worthy of respect and concern.’

<sup>118</sup> Joseph Raz *The Morality of Freedom* (1986) 369.

<sup>119</sup> Ronald Dworkin *Life’s Dominion: An Argument about Abortion and Euthanasia* (1993) 224.

<sup>120</sup> *Ibid.*

<sup>121</sup> *Ibid.*

<sup>122</sup> Viewed broadly as including one’s upbringing, social, religious and community values.

<sup>123</sup> *Op cit* note 118 at 369. Emphasis added.

<sup>124</sup> *Ibid* at 373.

<sup>125</sup> *Ibid* at 371.

— some good, some bad — every day. For the patient a treatment decision is freely made, that is, not coerced, if all the relevant information and reasonable options available have been presented, allowing him to choose any, or reject all, of those options, regardless of the medical practitioner's own preference — a 'bad choice' ought to be respected.

This philosophical understanding of the nature of the consent requirement finds strong support in our evolving constitutional law. The Constitutional Court has emphasized that dignity 'respect[s] . . . the intrinsic worth of all human beings' and that as a value it informs the interpretation of many, possibly all, rights and is not only 'a *value* fundamental to our Constitution, [but] . . . is a justiciable and enforceable *right* that must be respected and protected'.<sup>126</sup> Autonomy has been given constitutional protection in the form of the rights to life,<sup>127</sup> dignity,<sup>128</sup> privacy<sup>129</sup> and bodily integrity.<sup>130</sup> Discussing the right of individuals to choose their sexual preference Sachs J made the following comment regarding autonomy:

'While recognising the unique worth of each person the Constitution does not presuppose that a holder of rights is as an isolated, lonely and abstract figure possessing a disembodied and socially disconnected self. It acknowledges that people live in their bodies, their communities, their cultures, their places and their times.'<sup>131</sup>

Judge Sachs' comment recalls Raz's argument that although the truly independent and self-determining self is a theoretical construct, we still need to have the freedom and ability to make conscious rational choices, even though those choices may be influenced by external factors.

In medical law autonomy is directly opposed to paternalism, which involves the view that the doctor, not the patient, is the best person to make choices on behalf of the patient and to decide what information, if any, he ought to be told. In *Castell*, the court noted that medical paternalism 'stems largely from a bygone era predominantly marked by presently outmoded patriarchal attitudes'.<sup>132</sup>

Raz addresses the question 'to what extent, if at all, should . . . the law support paternalistic measures?'<sup>133</sup> He suggests that there are ways in which the state can assist its members to be autonomous individuals. First, 'securing the background conditions which enable a person to be autonomous'; secondly, 'to help in creating inner capacities required for the conduct of an autonomous life'; and thirdly, 'the creation of an adequate range of options

<sup>126</sup> *Dawood, Shalabi, Thomas and Others v Minister of Home Affairs* 2000 (3) SA 936 (CC) para 35 per O'Regan J (emphasis in judgment).

<sup>127</sup> Section 11. Cf *Re A (Minors) (Conjoined Twins: Separation)* [2000] Lloyd's Rep Med 425 at 494: 'Every human being's right to life carries with it, as an intrinsic part of it, rights of bodily integrity and autonomy — the right to have one's own body whole and intact and to take decisions about one's body.'

<sup>128</sup> Section 10.

<sup>129</sup> Section 14.

<sup>130</sup> Section 12(2). Paragraph (c) provides that no-one can be 'subjected to medical and scientific experiments without their informed consent'.

<sup>131</sup> Minority judgment in *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others* 1999 (1) SA 6 (CC) para 117.

<sup>132</sup> *Castell* supra note 2 at 422 quoting F Van Oosten *The Doctrine of Informed Consent in Medical Law* unpublished LL D thesis University of South Africa (1989) 414.

<sup>133</sup> Op cit note 118 at 401.

for him to choose from'.<sup>134</sup> In the state's provision of these conditions paternalism is a given — as it must decide what the background conditions, the inner capacities and the adequate range of options are. If we extend Raz's thinking to the law governing consent to medical treatment, legislative, policy and judicial interventions that assist in setting a benchmark of acceptable practice and which direct individuals to take responsibility for the decisions they make concerning their health, would not be unacceptably paternalistic but could be justified as promoting autonomy.<sup>135</sup>

Paternalism in this sense is justified because it takes into account the welfare, needs, interests and responsibilities of the person being coerced.<sup>136</sup> A society that encourages social and personal responsibility is one that helps to create those modes of behaviour that are integral to living autonomously. However, allowing medical practitioners to set the benchmark as to what constitutes adequate disclosure or which information should be withheld from the patient on the grounds that it might be detrimental to the patient's decision-making ability goes beyond the paternalism that Raz argues is justifiable. The courts in South Africa, Canada and Australia have in no uncertain terms held that setting the standard of adequate disclosure is their domain and it is submitted that this fits with Raz's notion of justifiable paternalism.<sup>137</sup>

When thinking about consent to treatment, it is important to remember that the main focus of autonomy is *choice* rather than consent as the term 'informed consent' implies. Perhaps the latter phrase should be jettisoned from the discourse in this area of law. The phrase 'informed consent' detracts from the aims of autonomy in three main ways. First, it incorrectly focuses on obtaining a patient's consent while in actual fact a refusal ought to be respected equally; secondly, it also suggests that a refusal must be measured according to a different standard — one that requires more or less disclosure; and thirdly, it assumes that the doctor's role is to provide the information and the patient's role is to consent.<sup>138</sup> 'Informed choice' or 'informed decision-making' reflects the underlying notion of autonomy better and should be preferred.<sup>139</sup>

<sup>134</sup> Ibid at 407--8.

<sup>135</sup> There is legislative and policy intervention in the form of the National Health Act 61 of 2003, the National Patients' Rights Charter, and the Health Professions Council of South Africa guidelines on consent (all discussed below).

<sup>136</sup> Gerald Dworkin 'Paternalism' in J Feinberg and J Coleman (eds) *Philosophy of Law* 6 ed (2000) 271.

<sup>137</sup> See *Castell* supra note 2 at 424; *Reibl v Hughes* supra note 50 at 895; and *Rogers v Whitaker* supra note 51 at 631--2.

<sup>138</sup> Ibid.

<sup>139</sup> B M Dickens 'The doctrine of 'informed consent': Informed choice in medical care' in R S Abella & M L Rothman (eds) *Justice Beyond Orwell* (1985) 243.

### 3.3 *Legislation*

#### 3.3.1 *The National Health Act*

The National Health Act<sup>140</sup> is an attempt to create a uniform legislative framework regulating health services in South Africa. It not only regulates the public health system but applies to all ‘health establishments’, which includes those in the private sector.<sup>141</sup> It also attempts to bring the current legislation regulating the health system in line with constitutional values as well as to fulfil the state’s duty ‘take reasonable legislative . . . measures’ in terms of the right of access to health care services contained in the Bill of Rights.<sup>142</sup>

Autonomy is recognized<sup>143</sup> and the Act makes specific reference to informed consent.<sup>144</sup> Chapter 2 of the Act sets out the rights and duties of ‘users’ (patients) in relation to healthcare providers.<sup>145</sup> Healthcare providers covered by the Act are not restricted to doctors working in the public health system but include those in the private sector, and the same is true of healthcare users.<sup>146</sup> In terms of the Act all healthcare providers are required to obtain a user’s informed consent.<sup>147</sup>

That a user has a right to *informed* consent is evidenced by every user’s right to participate in decisions affecting his health<sup>148</sup> and to have full knowledge regarding a proposed treatment. The content of s 6, entitled ‘user to have full knowledge’, is indicative of how informed consent is understood in the Act. In terms of this section, in order for consent to be informed, a healthcare provider must inform a user of his health status; the range of diagnostic procedures and treatment options generally available to him; the benefits, risks, costs and consequences generally associated with each option; and his right to refuse health services and the implications, risks, obligations of such refusal.<sup>149</sup> Furthermore, the health care provider must, where possible,

<sup>140</sup> Act 61 of 2003.

<sup>141</sup> Section 1 defines a ‘health establishment’ as ‘the whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services’.

<sup>142</sup> Section 27.

<sup>143</sup> See ss 6, 7, 8, & 12. Discussed below.

<sup>144</sup> Section 7. Discussed below.

<sup>145</sup> ‘User’ is defined in the Act, s 1 as ‘the person receiving treatment in a health establishment, including receiving blood or blood products, or using a health service.’

<sup>146</sup> Section 1 defines ‘health care provider’ as ‘a person providing health services in terms of any law, including in terms of the (b) Health Professions Act, 1974 (Act 56 of 1974);’, which establishes the Health Professions Council of South Africa (HPCSA) with whom all medical practitioners must be registered.

<sup>147</sup> Sections 6, 7 and 8. The term ‘informed consent’ is not defined in the Act but is used in s 7 where it is defined broadly as meaning ‘consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in section 6’.

<sup>148</sup> Section 8(1) provides: ‘A user has the right to participate in any decision affecting his or her personal health and treatment.’

<sup>149</sup> Section 6(1)(a) — (d). An exception is provided for in subsec (a), which allows a health care provider not to inform a user of their health status in circumstances where there is substantial evidence that the disclosure of the user’s health status would be contrary to the best interests of the user.

inform the user of all this information in a language that the he understands and in a manner that takes into account his level of literacy.<sup>150</sup>

This level of detail goes further than the standard of disclosure stipulated in *Castell*, which only requires knowledge and awareness of the nature and extent of the harm and material risks. However, it is submitted that the use of the word ‘generally’ in s 6 might limit the scope of knowledge that a user must have. Thus, one could argue that a user must be informed only of the procedures or treatments that are *generally* available and the risks *generally* associated therewith. Most likely, however, it will be given its ordinary meaning of ‘usually’ or ‘most commonly’ and thus, the requirement of materiality in respect of risks as set in *Castell* will remain unaffected. However, the Act does specifically provide that a user must be informed of the range of procedures and treatments available and the benefits and costs associated with the proposed options, which is more than is required by *Castell*; but again these are limited to those that are *generally* associated therewith.<sup>151</sup>

A further part of the ‘material risk test’ formulated in *Castell* is the ‘therapeutic privilege’.<sup>152</sup> The therapeutic privilege allows a medical practitioner to withhold certain information from the patient if, in his opinion, he thinks that the patient may not want to know the information or that it might distress the patient or dissuade him from undergoing the proposed treatment. Thus, any information, which the medical practitioner believes might be detrimental to the patient’s decision-making ability, can be withheld. The actual scope of the privilege has not been defined clearly in South African law.<sup>153</sup>

The Act retains the therapeutic privilege, allowing a healthcare provider to withhold information from a user ‘in circumstances where there is substantial evidence that the disclosure of the user’s health status would be contrary to the best interests of the user’.<sup>154</sup> But by making it an exception only to subsec (a), which concerns informing a user of her health status, and not the whole section, its ambit appears to be more limited than it is in the common law. The fact that the privilege makes inroads into a patient’s autonomy and right to self-determination cannot be denied.

The requirement of full disclosure,<sup>155</sup> the right of users to participate in decisions affecting their health<sup>156</sup> and the user’s right to refuse medical treatment<sup>157</sup> ensure that the Act gives effect to autonomy and self-determination. The Act takes the standard of disclosure further than the

<sup>150</sup> Section 6(2).

<sup>151</sup> Where a person has been unable to give his consent, s 8(3) provides that the information set out in s 6 must be made available to the user after the treatment has been administered. This is subject to the therapeutic privilege.

<sup>152</sup> *Castell* supra note 2 at 418.

<sup>153</sup> *Ibid* at 426.

<sup>154</sup> Section 6(1)(a).

<sup>155</sup> Section 6.

<sup>156</sup> Section 8.

<sup>157</sup> Section 6(1)(d).

common law, but as a result of using the word ‘generally’ and continuing to recognize the therapeutic privilege still refrains from requiring full disclosure.

Whether the scope of the common law duty is now determined by the Act or alongside the Act is not clear. In *Louvrens v Oldwage*,<sup>158</sup> handed down after the commencement of the Act, the court made no mention of the Act and only considered the common law, even though one of the questions before it was whether the consent was informed.

### 3.3.2 *The National Patients’ Rights Charter*

The National Patients’ Rights Charter<sup>159</sup> was created in terms of the constitutional mandate to set a common standard in achieving the realisation of the right of access to health care services, and as an endorsement of a human rights approach towards the provision of healthcare in South Africa.<sup>160</sup> At the launch of the Charter, the Minister of Health said that,

‘the Charter ought to be viewed as a tool to assist in changing our health system into a caring and compassionate health care delivery system, which will serve us all with pride, because for just too long have our services been characterised by indifference, arrogance negligence, covering up, and, at times, total disregard for human dignity, respect and privacy.’<sup>161</sup>

The Charter recognizes the right to informed consent. It states that:

‘Everyone has the right to be given full and accurate information about the nature of one’s illnesses, diagnostic procedures, the proposed treatment and the costs involved for one to make a decision that affects any one of these elements.’<sup>162</sup>

Although no specific reference is made to the disclosure of the risks and benefits of a procedure, it is suggested that this is implied by the words ‘diagnostic procedures’ and by the fact that the right itself is one to ‘informed consent’. The content of the right, however, requires ‘full’ information, which goes further than the current legal requirement of only ‘material risks’<sup>163</sup> and the broader definition in the National Health Act.<sup>164</sup> It is submitted that the Charter gives recognition to true patient autonomy.

Although the Charter was launched in 2001 and prior to the National Health Act, no reported cases concerning consent to treatment have referred to it. However, the ‘Charter provides an officially sanctioned baseline standard’ and ‘can be used as a tool of accountability by patients, health workers, broader civil society and institutions’.<sup>165</sup> It could be used by a court

<sup>158</sup> Supra note 5.

<sup>159</sup> Hereafter referred to as ‘the Charter’. Launched in late 1999. Available at [www.doh.gov.za/docs/legislation/patientsright/chartere.html](http://www.doh.gov.za/docs/legislation/patientsright/chartere.html).

<sup>160</sup> Section 27(2).

<sup>161</sup> Manto Tshabalala-Msimang, Minister of Health, Speech at the launch of the National Patients’ Rights Charter, 2 November 1999.

<sup>162</sup> Supra note 159.

<sup>163</sup> As required in *Castell* supra note 2 at 426.

<sup>164</sup> National Health Act, 2003 (note 159) s 6.

<sup>165</sup> Sandra Liebenberg Human Development and Human Rights South African Country Study *Human Development Report 2000* at 29, available at: [www.communitylawcentre.org.za/ser/docs\\_2002/South\\_African\\_Country\\_Study\\_HDR2000.doc](http://www.communitylawcentre.org.za/ser/docs_2002/South_African_Country_Study_HDR2000.doc).

to assess the current common law position, most notably whether the current standard of disclosure truly gives effect to constitutional values.

### 3.3.3 *The Health Professions Council of South Africa's Guidelines*

The Health Professions Council of South Africa (HPCSA) is a statutory body,<sup>166</sup> whose primary purpose is to regulate the health profession, promote the health of the population and set and maintain standards of ethical and professional practice.<sup>167</sup> In order to practise a health professional must be registered with the HPCSA. A collection of 15 booklets, issued by the HPCSA, set out ethical guidelines regarding a variety of topics for members of the profession.<sup>168</sup> The relevant booklets are: 'General ethical guidelines for medical practitioners and dentists'<sup>169</sup> and 'Seeking patients' consent: The ethical considerations'.<sup>170</sup> These guidelines are binding on members and could be used as the basis of an allegation of unprofessional conduct resulting in a disciplinary inquiry. Such inquiries allow for appeal, initially to an internal appeal committee, but could ultimately result in High Court proceedings.

Patient autonomy is expressly recognized and doctors are urged to respect it by '[h]onour[ing] patients' right to self-determination or to make their own informed choices, [taking into account their] . . . beliefs, values and preferences'.<sup>171</sup> Informed consent is also recognized, and according to the guidelines a doctor is expected to:

'Give . . . patients the information they ask for or need about their condition, its treatment and prognosis. Give information to . . . patients in the way they can best understand it. Refrain from withholding from . . . patients any information, investigation, treatment or procedure you know would be in their best interest. Apply the principle of informed consent as an on-going process.'<sup>172</sup>

In booklet 15, which deals specifically with consent, doctors are urged to allow patients to exercise their right to decide whether to undergo any medical intervention.<sup>173</sup> In the spirit of true autonomy, medical practitioners are reminded that even where a refusal may result in harm to a patient or in his own death, a patient has a right to refuse.<sup>174</sup> These guidelines further require that patients be given sufficient information, in a way that they can understand, to enable them to exercise their right to make informed decisions about their care.<sup>175</sup> The guidelines state that a doctor should not withhold information necessary for decision-making, unless he judges that the disclosure of some relevant information would cause the patient serious

<sup>166</sup> Established in terms of the Health Professions Act 56 of 1974.

<sup>167</sup> See s 3 of the Health Professions Act 56 of 1974 and the HPCSA website [www.hpcs.co.za](http://www.hpcs.co.za).

<sup>168</sup> Published in 2002. Available at [www.hpcs.co.za/professional-boards/Medical%20and%20Dental/Ethical.html](http://www.hpcs.co.za/professional-boards/Medical%20and%20Dental/Ethical.html).

<sup>169</sup> Booklet 1.

<sup>170</sup> Booklet 15.

<sup>171</sup> Booklet 1, clause 1.2.

<sup>172</sup> Booklet 1, clause 2.3.

<sup>173</sup> Clause 1.1.

<sup>174</sup> *Ibid.*

<sup>175</sup> Clause 2.1.

harm.<sup>176</sup> In this context, serious harm ‘does not mean the patient would become upset or decide to refuse treatment’.<sup>177</sup>

This negative definition nevertheless leaves open the question: ‘What is serious harm?’ It is submitted that no information should be withheld from the patient, unless the patient has unequivocally directed that at that particular point in time he does not want to know certain outcomes, risks or complications. Some patients are all too ready to allow their doctor to make decisions for them and that, too, is their autonomous choice, whether others approve of this choice or not. It would be prudent, however, for such a directive to be recorded in the doctor’s contemporaneous notes.

The guidelines traverse what constitutes sufficient information and also draw attention to the fact that the amount of information given to each patient will vary according to various factors.<sup>178</sup> Some of these factors are the nature of the condition, the complexity of the treatment, the risks associated with the treatment or procedure, and the patient’s own wishes. The guidelines also set out a detailed list of what information a patient may want or ought to know before deciding whether to consent to medical treatment.<sup>179</sup> Emphasis is also placed on a patient’s individual needs and priorities, such as religious or moral beliefs, culture and occupation.<sup>180</sup>

The extent of the information given in the guidelines is laudable and they go far in setting the benchmark for how informed consent should be obtained. They could also be used to flesh out the content of the provisions in the National Health Act and the Charter. They stress that the process of ‘obtaining informed consent cannot be,’ and is not, ‘an isolated event’.<sup>181</sup> As informed consent is premised on the idea of a patient’s right to self-determination, ‘it involves a continuing dialogue between [medical practitioner] and . . . patient . . . , in order to keep them abreast of any changes in their condition and the treatment . . . proposed’.<sup>182</sup> The guidelines also state that ‘whenever possible, . . . [a doctor] should discuss treatment options at a

<sup>176</sup> Clause 2.3.

<sup>177</sup> Clause 2.3.1.

<sup>178</sup> Clause 2.1.1.

<sup>179</sup> Clause 2.1.2: a. details of the diagnosis and prognosis, and the likely prognosis if the condition is left untreated; b. uncertainties about the diagnosis, including options for further investigation prior to treatment; c. options for treatment or management of the condition, including the option not to treat; d. the purpose of a proposed investigation or treatment; details of the procedures or therapies involved, including subsidiary treatment such as methods of pain relief; how the patient should prepare for the procedure; and details of what the patient might experience during or after the procedure including common and serious side effects; e. for each option, explanations of the likely benefits and the probabilities of success; and discussion of any serious or frequently occurring risks, and of any lifestyle changes which may be caused or necessitated by the treatment; f. advice about whether a proposed treatment is experimental; g. how and when the patient’s condition and any side effects will be monitored or reassessed; h. the name of the medical practitioner who will have overall responsibility for the treatment and, where appropriate, names of the senior members of his or her team; i. whether medical practitioners in training will be involved, and the extent to which students may be involved in an investigation or treatment; j. a reminder that patients can change their minds about a decision at any time; k. a reminder that patients have a right to seek a second opinion; l. where applicable, details of costs or charges which the patient may have to meet.

<sup>180</sup> Clause 2.1.3.

<sup>181</sup> Clause 2.4.1.

<sup>182</sup> *Ibid.*

time when the patient is best able to understand and retain the information'.<sup>183</sup> In order to ensure this, various suggestions are made and, it is submitted, this checklist should be routinely used in the process of obtaining a patient's informed consent.<sup>184</sup> Besides this checklist, the guidelines are general in nature, setting out general requirements for the informed consent process. It is submitted that when it comes to specific commonly diagnosed and performed procedures, a related checklist setting out which information should be disclosed would be useful to assist medical practitioners to obtain a patient's informed consent. In respect of a particular procedure or diagnosis a checklist could set out the options available to a patient for treatment of that condition, as well as their likelihood of success, the associated risks and complications.<sup>185</sup>

The duty on members of the HPSCA to follow the guidelines is ethical rather than legal, although, as mentioned above, disciplinary action may be instituted in the event of a complaint. In booklet 15 doctors are reminded that the right to autonomy is one that is protected in law and that they are expected to be aware of the legal principles set by relevant case law in that area.<sup>186</sup> However, the existing law only sets out what can be considered the minimum requirements of good practice in seeking informed consent from patients. As a professional one is expected to act in an ethical manner befitting one's profession and this may often require one to act over and above that which is required by law.

The HPCSA guidelines give considerable guidance as to what needs to be traversed in a discussion between a medical practitioner and patient regarding proposed treatment. Although these booklets have no legal force, it is submitted that they carry substantial evidentiary value of acceptable and reasonable practice in the provision of information regarding medical treatment. The fact that they have been drafted in consultation with the medical profession, lawyers and ethicists also gives them added weight. It is submitted that a court in an action for professional negligence ought to use its

<sup>183</sup> *Ibid.*

<sup>184</sup> These suggestions are: a. use up-to-date written material, visual and other aids to explain complex aspects of the investigation, diagnosis or treatment where appropriate and/or practicable; b. make arrangements, wherever possible, to meet particular language and communication needs, for example through translations, independent interpreters, signers, or the patient's representative; c. where appropriate, discuss with patients the possibility of bringing a relative or friend, or making a tape recording of the consultation; d. explain the probabilities of success, or the risk of failure of, or harm associated with options for treatment, using accurate data; e. ensure that information which patients may find distressing is given to them in a considerate way. Provide patients with information about counselling services and patient support groups, where appropriate; f. allow patients sufficient time to reflect, before and after making a decision, especially where the information is complex or the severity of the risks is great. Where patients have difficulty understanding information, or there is a lot of information to absorb, it may be appropriate to provide it in manageable amounts, with appropriate written or other back-up material, over a period of time, or to repeat it; g. involve nursing or other members of the health care team in discussions with the patient, where appropriate. They may have valuable knowledge of the patient's background or particular concerns, for example in identifying what risks the patient should be told about; h. ensure that, where treatment is not to start until some time after consent has been obtained, patients are given a clear route for reviewing their decision with the person providing the treatment.

<sup>185</sup> Australian Law Reform Commission *Informed Decisions about Medical Procedures* Report 50 (1989) 26 para 48.

<sup>186</sup> Clause 1.2.

inherent jurisdiction and consider the guidelines, calling on the defendant to explain to the court why he did not comply with the guidelines or thought it would be reasonable not to comply.<sup>187</sup> The guidelines could also expressly be given evidentiary value<sup>188</sup> and 'be made conclusive evidence' of the standard of care required in disclosure of information about any proposed procedures or treatment, or of what constitutes 'approved professional practice'.<sup>189</sup> The result of giving them evidentiary value would be much the same as extending the common law standard, only through a different channel.

## 5. CONCLUSION

The increased focus since *Castell*, in litigation, legislation and policy documents, on consent to medical treatment is indicative of a growing respect for patient autonomy, the involvement of the patient in the decision-making process, as well as of the increasing external regulation of a traditionally self-regulated profession.

Furthermore, the South African constitutional framework recognizes the fundamental importance of dignity, autonomy and the intrinsic worth of each person in contemporary society.<sup>190</sup> The Constitutional Court has said that dignity is not only a fundamental value, but a justiciable and enforceable right that has to be respected and protected.<sup>191</sup> Any inquiry by a court into questions relating to consent to medical treatment and the disclosure of risks must be premised on these core values and attempt to give effect to them. And if the common law does not sufficiently reflect the values of dignity, autonomy and self-determination, then the courts are under a constitutional duty to develop it.

The National Health Act and the Patients' Rights Charter also bear out the view that autonomy is always the starting point of consent to treatment. The Act provides that informed consent is a 'participatory process' between the doctor and patient and involves more than knowledge of material risks but extends to knowledge about the benefits, costs and consequences of the options available. These documents, along with the HPCSA guidelines, recognize that one patient's choices and needs regarding a medical procedure might be different to those of another.

Allowing the particular patient's concerns, expectations and needs to be the starting point of an inquiry need not compromise a court's ability to make a good decision. As the majority of the cases agree, the court is always the final arbiter and can assess the plaintiff's evidence against the standard of what a reasonable patient would have done, thereby carrying out a balancing between subjective and objective standards. Furthermore, the court is under

<sup>187</sup> In Australian Law Reform Commission op cit note 185 at 29--30 it is suggested that legislation to this effect should be enacted.

<sup>188</sup> As was suggested in Australian Law Reform Commission op cit note 185.

<sup>189</sup> The term used by Chief Justice King in *F v R* supra note 60.

<sup>190</sup> *Prinsloo v Van der Linde and Another* 1997 (3) SA 1012 (CC) para 31.

<sup>191</sup> *Dawood and Another v Minister of Home Affairs* supra note 132 at 841.

a duty to give effect to the underlying purpose of informed consent, which is to avoid the occurrence of an injury for which the patient is unprepared and to respect his or her autonomy and dignity.<sup>192</sup>

The legal standard merely sets the *minimum* level of acceptable professional practice and should thus only be the starting point of any inquiry. In this regard one must bear in mind Kirby J's comment in *Rosenberg v Percival* that setting rigorous legal standards ensures that those doctors who may be in a hurry or less skilled or less inclined to communicate, pause and provide warnings, thereby bringing about a change in practice. Doctors may have concerns regarding the fallibility of treatment and be unwilling to be honest with their patients for fear of alarming or harming the patient or they may be under great pressure and time constraints.<sup>193</sup> Conversely, patients may expect their doctor to make their decision for them, be unwilling to know the facts of the situation because of fear and denial or they may require too much of the doctor's time in order really to understand what their treatment entails.<sup>194</sup> For these reasons a doctor may 'dismiss the informed consent requirement as a meaningless but bureaucratically necessary ritual'.<sup>195</sup> None of these concerns is a valid reason for dismissing the importance of obtaining informed consent to medical treatment. The process of informed consent is an opportunity for doctors to enter into a 'new and unaccustomed dialogue with their patients, through which both, appreciative of their respective inequalities, make a genuine effort to voice and clarify their uncertainties and then arrive at a mutually satisfactory course of action'.<sup>196</sup>

The current the South African common law duty of disclosure, especially as applied by the SCA in *Louwrens v Oldwage*,<sup>197</sup> falls short of the true ambit of informed consent. It should therefore be extended in order adequately to reflect the constitutional rights of dignity and bodily integrity as well as recent developments in domestic legislation and policy and in foreign case law. A more precise and appropriate standard of disclosure might read as follows:

'Recognising the importance of the rights to dignity and bodily integrity, the duty of disclosure requires that the patient must be informed of the material risks and benefits, as well as any other special or unusual risks and benefits that the particular patient would have considered material. In determining which risks and benefits the patient would have considered material, the medical practitioner should have regard to the particular patient's concerns, that is, those that the patient volunteered and those discovered through questioning. The patient must also be apprised of the alternatives, with their risks and benefits, and the costs involved. The risks to the particular patient of sustaining the injuries, the inherent risks of injury that arise from rare and random causes in every surgical procedure, those unavoidable risks that cannot be eliminated by the exercise of reasonable care and those risks, though slight, with serious consequences, such as death or paralysis, that should also be disclosed. The duty should begin when the patient walks into the consulting room and end when the whole course of treatment is complete.'

<sup>192</sup> *Chester* supra note 99 at 594 para 18 per Lord Steyn.

<sup>193</sup> Albert R. Jonsen et al *Clinical Ethics* 3 ed (1996) 43.

<sup>194</sup> Australian Law Reform Commission op cit note 185 at 43.

<sup>195</sup> *Ibid.*

<sup>196</sup> *Ibid.*

<sup>197</sup> *Supra* note 5.

The therapeutic privilege, the ambit of which the court in *Castell* failed to define, also needs to be re-examined.<sup>198</sup> Although not the focus of this paper, it is not difficult to see how the therapeutic privilege is contrary to the notion of autonomy. Considering the increased focus on human rights in the last ten years and the concomitant constitutional duty of the courts to develop the common law, I believe that in the future South African courts should flesh out this concept and limit its ambit.

Future court decisions might also re-examine the continued use of the phrase 'informed consent'. If South African society is founded on the notions of dignity and autonomy, as the Constitutional Court has said it is, then perhaps it is time for the language of the law to reflect this clearly by introducing the more accurate terminology of 'informed choice' or 'informed decision-making'.

<sup>198</sup> *Castell* supra note 2 at 426.