Certainty of law

“ … the law must aspire at certainty, at justice, at progressiveness. That is so only if the courts from time to time boldly lay down new principles to meet new social problems. ”

—Raja Azlan Shah J (as he then was)
Public Prosecutor v Masran bin Abu & Ors
(1971) 4 MC 192, HC at 193

HRH Sultan Azlan Shah

The Royal Family

His Royal Highness Sultan Azlan Shah married Her Royal Highness Tuanku Bainun Mohamad Ali in 1955. Her Royal Highness Tuanku Bainun is often described as "an epitome of serene and dignified grace". A qualified teacher, trained at Kirkby Teachers' College, England, she is currently the Chancellor of Universiti Pendidikan Sultan Idris.

Their Royal Highnesses have five children, all with outstanding academic qualifications. "The personal achievements of each child is much attributed to the wisdom and nurturing care of Their Royal Highnesses."

The eldest, His Royal Highness Raja Nazrin Shah, who is also the Raja Muda of the State of Perak (Crown Prince), received an undergraduate degree from Worcester College, Oxford University. He then obtained a Masters and Doctor of Philosophy (PhD) in Political Economy and Government from the Kennedy School of Government, Harvard University.

Their second child, Her Highness Raja Dato' Seri Azureen is a graduate of the Syracuse University of the United States, and also holds a Masters degree from the London Business School. She is married to Dato' Seri Mohamed Salleh bin Dato' Mohd Ismail.

Their third child is His Highness Raja Dato' Seri Ashman Shah who is the Raja Kechil Tengah of the State of Perak. He is a holder of a Masters degree from Cambridge University, having done his undergraduate studies at Nottingham University. Like his father, he is a Barrister-at-Law at Lincoln's Inn. He is married to Dato' Seri Noraini Jane bt Tan Seri Kamarul Ariffin.

Her Highness Raja Dato' Seri Eleena, the fourth child, graduated from the School of Oriental and African Studies, University of London. She is also a Barrister-at-Law from Lincoln's Inn, and is currently in private practice. She is married to Dato' Seri Ismail Farouk bin Dato Abdullah.

The youngest, Her Highness Raja Dato' Seri Yong Sofia, is a holder of a Masters degree in Business, and was working as a senior executive in a leading bank. She is married to Tungku Dato' Seri Kamel bin Tunku Rijaludin.

“The doctor is ethically bound to disclose all necessary information of a particular treatment so as to allow the patient to make his own decision as to whether he wishes to accept that treatment. However, it is felt that a compromise has to be struck between ‘medical paternalism’ and ‘patient sovereignty’.”

—HRH Sultan Azlan Shah
Medicine, Ethics and the Law

9

Medicine, Ethics and the Law

The 8th Tun (Dr) Ismail Oration
The Academy of Medicine, Malaysia,
Kuala Lumpur, 5 October 1989

The medical profession, more so than any other profession, has always been held in high esteem by society. The relationship between a doctor and his patient is quite different from that of a lawyer and his client or that of any other professional and his client. A client dealing with a lawyer, an accountant or even an engineer does not place such trust as he would, if he were a patient, in his doctor. In most cases, a patient places complete trust in his doctor. The fundamental reason for this unique relationship is that generally, society has always regarded doctors as samaritans who are always there to provide services to the sick.

In many countries, medical services are available to the public as a social service provided for by the government. Therefore, in most cases, a patient who sees a doctor need not negotiate the

fees or even entertain any doubt as to whether he would obtain the best available service from the doctor. The trust is so great that a patient readily "puts his life into the hands of a doctor". The public perception of the medical profession is such that they know that doctors are the only ones who would provide a service night or day and who would make all sacrifices to treat the sick. Furthermore, doctors are the only ones who are able to perform "miracles"—to create life and to prolong it.

This special relationship, of course, meant that there was little necessity to have regulations to control the practice of medicine. The doctor's high sense of integrity and dedication was deemed sufficient. The Hippocratic oath and a code of medical ethics were in themselves regarded as sufficient to regulate the practice of the profession. It was for this reason that the practice of medicine has always been self-regulatory.

Unfortunately, this perception of the medical profession has now begun to change. Not only has the number of legal actions against doctors for medical negligence increased over the years but with recent medical advances and discoveries, society has begun to question some of these practices. With the establishment of a number of interest or pressure groups, there has now begun to emerge a trend to question some aspects of medical practice and research. It is no longer felt that certain practices concern the patient alone but rather that they affect society as a whole.

Let me give an obvious example: the question of abortion. Like in many other areas of medical development, an abortion may now be performed with hardly any risk to a woman. A doctor may therefore argue that if a woman so desires to have an abortion and that if there is no attendant risk, there should be no reason why the

abortion shall not be performed. A prudent doctor, however, will consult a book on the law and would soon learn that (if there is no legislation on the point) only the killing of a human being or a person is an offence. The foetus, he may argue, is by no definition a human being or a person and therefore no wrong is being committed in the performance of the abortion. Well, this may be true this far. However, a moralist will be quick to point out that though the foetus is not a human being or a person as the term is commonly understood to mean, yet it has all the features of becoming a human being within a couple of weeks. Therefore, he would say that an abortion tantamounts to murder.[1]

> It is clear that legal and ethical issues now govern the practice of medicine. A doctor has now to consider not only the medical aspects of a particular issue but also the legal and ethical issues relating to it.

Furthermore, whilst previously it was thought that it was the absolute right of a woman to have an abortion, the question of abortion has now aroused such great public interest that the position in many countries presently is that such a right is no longer vested in a woman alone. Society in general claims a right on the issue of abortion and therefore demands that it be regulated by legislation. It is therefore clear from this example alone that legal and ethical issues now govern the practice of medicine. A doctor has now to consider not only the medical aspects of a particular issue but also the legal and ethical issues relating to it.

A few years ago, an address or a talk by a lawyer on the practice of medicine or a talk by a doctor on the practice of law

1
Kennedy, "The Moral Status of the Embryo" in *Treat Me Right: Essays in Medical Law and Ethics,* 1988, Oxford University Press, pages 119–139.
See also Report of the Law Reform Commission of Canada, *Crimes Against the Foetus,* Working Paper 58, (1989);
Report of the Committee Of inquiry Into Human Fertilisation and Embryology, Cmnd 9314 (1984) (the Warnock Report); and
The White Paper on *Human Fertilisation and Embryology: A Framework for Legislation,* Cm 259.

would have been viewed with suspicion. The practice or the study of either of these two disciplines was so independent that it was generally believed that there was no relation between these two professions: the doctor's duty was to treat the sick whereas the lawyer's duty was to protect the rights of his client. It was further thought that questions of ethics were within the domain of the philosopher. However, there is now a general awareness of the inter-disciplinary nature of the practice of law and medicine. Certain medical practices have highlighted the interface not only between law and medicine but also philosophy.

There is now a general awareness of the inter-disciplinary nature of the practice of law and medicine.

Much of the current uncertainties in the law in the area of medicine have been due to the rapid advancement of medical research. This has further been accelerated by technological developments. Whilst the ethical issues may be clear, the legal issues remain blurred. In almost all new medical developments, the legal implications have only been tested after the event. New laws, if introduced by the legislature, were enacted only after there had been adverse public response to a particular medical treatment on ethical grounds. Therefore, where there was no specific legislation on a particular aspect of medical treatment, the legality of such treatment remained in the "grey" area of the law.

In certain cases, however, where the common law system was applicable, judges were able to adopt and extend the existing common law to meet new situations. For example, in the most recent decision[2] on medical practice reported just a couple of months ago,

2 *F v West Berkshire Health Authority & Anor* [1989] 2 All ER 545, HL.

the House of Lords applied the common law rules as expounded way back as early as 1704. But in some cases, without the intervention of Parliament, a lacuna in the law prevailed. The development of the common law in these areas of medical practice, together with the enactment of new legislation on the practice of medicine, has now contributed to the development of a new branch of jurisprudence, which is now termed medical law.[3]

The closest most of you as doctors would have probably come in contact with the study of law would have been in a subject introduced in some universities on medico-jurisprudence. I may add that if you have had the opportunity, you may be better off than a lawyer who throughout his course of studies is not introduced to any course in the study of medicine (not even forensic medicine). The proliferation of literature[4] on the legal and philosophical aspects of medical practice over the last couple of years is a clear manifestation of the interest generated amongst doctors, lawyers and philosophers in some areas of medical practice. Even the most conservative of legal writers have now acknowledged the existence of a separate branch of the law called, as I have said, medical law.[5] Universities in many countries have recognised the importance of this development and have established departments and have introduced special courses on medical jurisprudence or medical law.

In delivering a lecture on Medicine, Ethics and the Law, I have some apprehension. I profess to be no doctor or philosopher. However with that caveat, I hope this evening to highlight to you certain issues which are not only current but which also demonstrate the inter-disciplinary nature of these three professions (though some may take issue with me for referring to philosophy as a profession). Furthermore, what I intend to address you on are

3
Kennedy, *Treat Me Right*. See also *All England Law Reports Annual Reviews* 1987 and 1988.

4
Kennedy, *Treat Me Right;*
Freeman, *Medicine, Ethics and the Law,* 1988, Stevens & Sons;
Skegg, *Law, Ethics and Medicine: Studies in Medical Law,* 1988, (paperback, revised edition), Oxford University Press;
Mason & McCall Smith, *Law and Medical Ethics,* 1983, Butterworths;
Brazier, *Medicine, Patients and the Law,* 1987, Penguin.
For an excellent bibliography on the subject of 'Law, Medicine and Ethics', see Kennedy, *Treat Me Right,* pages 365–370.

5
For example, see *The All England Law Reports, Annual Review.*

certain wider issues affecting society as a whole: issues like abortion, sterilisation, the mentally handicapped, care of the terminally ill, euthanasia, suicide, surrogate mothers, and others. Though these issues generally reflect the economic and religious mores of a particular society, more often than not, the ethical considerations involved in these issues apply to every society—after all, all of these issues relate to basic human values.

I should perhaps, at this stage, remind you what Lord Coleridge CJ said over a hundred years ago:

> It would not be correct to say that every moral obligation involves a legal duty, but every legal duty is founded on a moral obligation.[6]

This observation remains true even today. Therefore, until these ethical issues are translated into legal issues, they remain ethical issues. Where legislation has been introduced in certain countries on any of these issues, other countries may be able to learn something from their experiences.

Birth and death

In all societies, irrespective of their religious and cultural backgrounds, the phenomena of birth and death of a human being have always been shrouded by mystery. Whilst scientists, theologians and philosophers debated on the issues relating to the birth and death of a human being, they were unable to provide any rational conclusion to the creation of a human being and the ultimate death of it. The theologians, however, seem to have had an edge in solving this mystery: they held the view that man is the creation of God. Only He is able to bring life and to end it by way of death.

6 *R v Instan* [1893] 1 QB 450 at 453.

Though this premise seems acceptable to most communities, the diversity of religious and cultural perspectives, however, raised other conflicting issues. The values and beliefs of a community generally tended to reflect the particular religious principles which that community subscribed to. Where laws were deemed necessary to regulate certain conduct, the laws introduced merely gave effect to these particular beliefs and values.

You, therefore, as doctors may have dealt with patients with diverse beliefs. Some believe that a foetus is the creation of the Almighty and therefore is a living being from the time of its conception. Therefore, any attempt to tamper with it is a wrong committed against the Creator. There are others who paradoxically accept this view, but take a different view to capital punishment. In certain societies, there are people who strongly believe that any form of medical treatment is against the Creator's design. Based on such a belief, they even refuse blood transfusion, an operation or any form of treatment.[7]

I should perhaps also point out that it is not only the creation of a human being which has caused so much uncertainties but also the termination of it. The definition or meaning of "death" continues to be a difficult question, not only to the philosopher but to the lawyer as well as the doctor.[8]

The point which I wish to stress is that the questions relating to the creation of life and of death have in most communities been treated as sacrosanct. The more relevant question to be addressed now is how then these communities, who hold such strong beliefs, have reacted to new medical technologies, such as in vitro fertilisation, or freezing of embryos or to womb-leasing (now commonly called "surrogate motherhood").[9]

7
Skegg, *Law, Ethics and Medicine,* pages 106–110, 112–114, 156 and 157.

8
Skegg, *Law, Ethics and Medicine*, pages 183–227; Brazier, "Defining Death" in *Medicine, Patients and the Law,* pages 297–304.

9
Kennedy, *Treat Me Right,* page 119;
New South Wales Law Reform Commission, *Surrogate Motherhood*, Discussion Paper 3, 1988;
Report of the New South Wales Law Reform Commission on Surrogate Motherhood, 1988 (LRC 60);
New South Wales Law Reform Commission, *In Vitro Fertilization, Discussion Paper 2,* 1987;
Report of the New South Wales Law Reform Commission on In Vitro Fertilization, 1988 (LRC 58).

Whilst at one stage of medical development, the main issue relating to the unborn was whether a woman had a right to have an abortion, now a number of other ethical and legal issues relating to the foetus have been raised, the answers to which still remain unclear. Does a husband have a right to prevent his wife from having an abortion?[10] Does a woman have a right to sue the doctor for an unwanted birth of a child?[11] Can an action be brought by a handicapped child for "wrongful life" on the ground that he should never have been born?[12] Far-fetched as these examples may seem to be, yet such actions have been instituted not only in the United States but also in the United Kingdom.[13]

Artificial insemination and surrogate motherhood

The current debate concerning reproductive technologies has raised a number of ethical and legal issues. The development of in vitro fertilisation (IVF) and womb-leasing (surrogate motherhood) would seem to be medical responses to human infertility. These new reproductive technologies, whilst performing "miracles" to infertile couples, have raised other difficult issues. One major difficulty has been in the area of enacting laws to regulate these technological discoveries and the practice of such methods of artificial conception. To what extent should laws be introduced? Should the law prohibit all forms of artificial insemination? If not, should such practices be regulated, and if so to what extent?

Whether laws should be introduced depends on a particular community's attitude towards such forms of reproductive processes. Is it ethical? Is it forbidden by the religion?

10 *Paton v Trustees of BPAS* [1978] 2 All ER 987. See views of Kennedy in *Treat Me Right*, pages 42–51 on this case.

11 Grubb, "Conceiving—A New Cause of Action" in *Medicine, Ethics and the Law*, 1988, Stevens, and the cases referred to therein.

12 *McKay v Essex Area Health Authority* [1982] 2 All ER 771. The essence of such an action is that the doctor negligently deprived the mother of the opportunity of an abortion so that a child has to live a life of suffering. See also Grubb, *Medicine, Ethics and the Law*.

13 Grubb, *Medicine, Ethics and the Law*, pages 121–146.

The question as to whether laws should be introduced, of course, depends on a particular community's attitude towards such forms of reproductive processes. Is it ethical? Is it forbidden by the religion? Furthermore, there are other wider issues such as: should the law interfere with an individual's right to choose a particular treatment which causes no harm to others? Or should the law take into consideration public opinion?

Should the law interfere with an individual's right to choose a particular treatment which causes no harm to others? Or should the law take into consideration public opinion?

Some argue by saying that legislation is the most effective means of subjecting scientists and doctors to the values subscribed by the community. However, difficulties are also caused to the lawmaker. He knows that no sooner has he drafted a piece of legislation on a particular medical practice, that law would be outdated with the invention of further new techniques and discoveries. Moreover, even the attitudes of a community may change with time, especially so when the public becomes more familiar with certain of these new techniques. The difficulties faced by legal draftsmen in keeping abreast with scientific advances have been aptly described as follows:

> Scientific material is always provisional and is constantly becoming out of date, so that yesterday's truth is today's error. Unfortunately, however, in the law, yesterday's belief … becomes authority for today.[14]

On the question of in vitro fertilization and womb-leasing a compromise has to be struck between the rights of individuals

14 Brett, "Implications of Science for the Law" (1972) 18 McGill Law Journal, 170 and 184.

"to marry and found a family" as stated in Article 16 of the United Nations Declaration of Women's Rights 1948, and society's responsibilities to ensure the welfare of a child born through a technological process. Whilst there is no doubt that in vitro fertilisation is a technique which enables an infertile couple to have a child, which may be regarded by some as a private matter for the couple, yet religious, moral, social and legal sentiments may be put forth against such an argument. Opponents of IVF and other biotechnological processes of fertilisation regard such forms of conception as unnatural and dehumanizing.[15] One major fear, as pointed out by the Law Commission of New South Wales, is that:

> … acceptance of IVF inevitably leads to acceptance of the notion of "manufacturing" replacing natural procreation. When these technologies are viewed as tools to achieve eugenic designs, there must necessarily be consideration of their potential for interfering with evolutionary processes …[16]

On the question of in vitro fertilization and womb-leasing a compromise has to be struck between the rights of individuals "to marry and found a family" and society's responsibilities to ensure the welfare of a child born through a technological process.

Others raise objections on religious grounds. For example, the attitude of the Catholic Church is that the use of IVF by married couples is "illicit".[17]

Those who support these new medical practices argue that such methods result in a planned and wanted pregnancy which has

15
New South Wales Law Reform Commission, *In Vitro Fertilization, Discussion Paper 2,* 1987, paragraph 4.16.

16
Ibid, at paragraph 4.34.

17
Instruction on Respect for Human Life in its Origin and on The Dignity of Procreation — Replies to Certain Questions of the Day, given at Rome from the Congregation for the Doctrine of the Faith on 22 February 1987. The Instruction was approved by Pope John Paul II and published by his Order: referred to by the New South Wales Law Reform Commission, *In Vitro Fertilization, Discussion Paper 2,* 1987, paragraph 4.13.

previously been denied through infertility. They further contend that in any case, "every medical intervention is a disturbance to the cause of nature and a departure from the normal course of events".[18]

In communities which share a common social, religious and cultural background, such problems may be alleviated. However, in a multi-racial and multi-cultural community where the morality of one group of the community is not necessarily shared by the others, the determination of public opinion becomes more difficult.

One strong argument which has been used against legalising such practices has been the concern of society towards the welfare of not only the child born of the IVF process (or any other technological process) but also of the emotional and psychological implications for the parties to the IVF. It is probably too early to state with any certainty the extent of the mental and psychological implications on the parents and the child born through the process of artificial insemination. In cases of surrogacy it has, however, been argued that the degradation and trauma suffered by the surrogate mother in carrying the child and transferring custody places great emotional pressure on the surrogate mother.

Furthermore, concern has been expressed that undue influence may be exercised by a husband over his wife to get her consent on the use of a surrogate. Finally, others have argued by saying that by these processes, nature's way of dealing with child-bearing and motherhood and the bondage of the child and its mother are completely demolished.

Besides the ethical issues, there are also a number of legal issues arising from IVF and surrogate motherhood. The law has generally regarded the woman who bears a child as the child's

18
New South Wales Law Reform Commission, *In Vitro Fertilization, Discussion Paper 2*, 1987, paragraph 4.17.

genetic parent (mother). With the advent of IVF technology, it is now possible for the "birth" mother (the woman who carries the child and gives birth to it) not to be the child's genetic mother (the donor of the reproductive tissue). Under some legal systems, a woman who gives birth to a child through a donation from a man who is not her husband, is said to commit adultery. Such a child born is also regarded in law as illegitimate.

Even in other legal systems which do not take such a stand, other legal problems arise: who is the father of a child born through such a process—he need not necessarily be the husband of the woman who carried the child. This is relevant for purposes of registration of the birth of the child under any relevant law.

Under some legal systems, a woman who gives birth to a child through a donation from a man who is not her husband, is said to commit adultery. Such a child born is also regarded in law as illegitimate.

Further, legal problems are raised by the posthumous use of stored gametes or stored embryos.[19] Is a child born through the use of such processes entitled to inheritance? How does the law of inheritance and succession apply in such cases?

Two particular legal problems have already arisen in some countries where surrogate motherhood has been practised, especially under a surrogacy agreement—first, the question as to who the legal mother of such a child is: is she the surrogate mother (that is the woman who bears the child) or is she the woman (the wife of the donor) who commissions the surrogacy? Secondly, what is the effect

19 Morgan, "Technology and the Political Economy of Reproduction" *in Medicine, Ethics and the Law*, note 11 above, page 32 and *The New South Wales Law Reform Commission Report on In Vitro Fertilization*, 1988 (LRC 58), page 85.
See also the recent English Court of Appeal decision in *Re C (a minor) (wardship: medical treatment) (No 1)* [1989] 2 All ER 782.

of a surrogacy agreement? Is it enforceable in a court of law? Is there any distinction to be drawn between a surrogacy agreement entered into by a woman to carry the child for no reward and an agreement where the woman does so purely for purposes of reward?

These are amongst the two main legal issues drafters of any legislation on surrogacy have to address their minds to. This has been no easy task for legal draftsmen in England, Australia and other countries, especially when members of the legal and medical professions, psychologists, family planners, brokers, commissioning parents, the surrogate mother and finally the child, are all affected by such arrangements.

I have stated earlier that actions have been brought by parents and children against doctors for wrongful birth or wrongful life. Though so far these actions have been brought by parents or children born through the natural process, doctors should be aware that they may equally be made liable for such actions in cases of birth through the biotechnological process. It is possible in the case of an unexpected multiple IVF pregnancy, the parents might bring a wrongful birth action in respect of their "excess" offspring.

The New South Wales Law Reform Commission on *In Vitro Fertilization*[20] gives the following possibility: In October 1985 in California, a woman who had been treated with infertility drugs gave birth to seven babies from the same pregnancy, three of whom lived. She and her husband claimed damages of Australian $4.5 million from the medical practitioners who prescribed the drugs, alleging negligence and wrongful death. Had all the children survived, perhaps the couple could have brought a "wrongful birth" action, claiming that by reason of the doctor's negligence more babies had been born than were wanted.

20
New South Wales Law Reform Commission, *In Vitro Fertilization, Discussion Paper 2,* 1987, paragraph 10.26, note 31.

Such are the ironies of life—in assisting in the conception of infertile couples, you as doctors may be sued for "too many babies"! This may not be the end of the story:

> Even if the IVF child has not suffered physical injury as a result of the IVF process, he or she might claim that a person necessarily suffers damage by being born as a result of IVF. It is possible, by means of the same reasoning, to envisage a claim by an IVF child against its parents alleging that it should not have been conceived.[21]

Consent and the right to know

I now move on to address you on another familiar aspect of medical practice which has recently been considered by the courts. This is the question of consent. Two main issues, both relating to law and ethics which have plagued doctors for a long time, have been the questions:

(i) When and under what circumstances can a doctor give treatment to a patient without the express consent of the patient? and

(ii) How much of information, both as to the treatment to be given, and to the medical condition of the patient, should the doctor disclose to the patient?

Regarding the first issue, it is of course the standard medical practice for doctors to obtain the express consent of a patient whenever possible before any medical treatment is given to the patient. But as you probably know better, it is not always possible

21 Ibid, at paragraph 10.26.

to get a patient to sign a document giving his express consent in every situation before an operation may be performed on him, for example, as in the case of an unconscious victim of a road accident. In such a situation, what does the doctor do?

> Two main issues have plagued doctors for a long time: When and under what circumstances can a doctor give treatment to a patient without the express consent of the patient? How much of information, both as to the treatment to be given and to the medical condition of the patient, should the doctor disclose to the patient?

Ethically, of course, the doctor will feel compelled to give whatever treatment, including performing an operation, which he feels ought to be given to ease the pain and agony of the patient or, in some cases, even to save his life.

The question which often confronts the doctor in such circumstances is to determine the extent of treatment which a doctor may give to such a patient who is not in a position to give his express consent. Is the doctor only under an obligation to give that much of treatment as is necessary so as to make the patient well enough to give his express consent for any further treatment which he may need? For example, if in treating an accident victim, the doctor performs an emergency operation to save the life of the victim, is the doctor under a duty to perform some other operations on the victim for some other ailments which the doctor comes to know of during the course of the first operation? Or, is the

doctor under a duty to postpone the second operation until after the patient has regained consciousness so that his consent for the second operation may be obtained?

The whole question of consent in the context of medical care is both a legal and ethical issue. Every person has a right to his own autonomy, his power to make his own decisions and to act on them.

Generally speaking, of course, the whole question of consent in the context of medical care is both a legal and ethical issue. The basis for this is that every person has a right to his own autonomy, his power to make his own decisions and to act on them:

> Consent is one aspect of respect for autonomy. In the context of medical ethics, it means that a doctor may not touch or treat a person without his consent, always assuming that the person is competent to make an autonomous decision.[22]

Such a theory is, of course, based on the assumption that the person is competent to make an autonomous decision. Therefore the unconscious person, the immatured, the mentally ill, may by definition be incompetent.

From a legal point of view, the basis for obtaining consent before medical treatment is as follows. The fundamental principle which the law recognises is that:

> Every person's body is inviolate; [therefore] everybody is protected not only against physical injury but against any form of molestation.[23]

22
Kennedy, *Treat Me Right,* page 177. See also Skegg, *Law, Ethics and Medicine,* pages 75–117.

23
Per Lord Goff in *F v West Berkshire Health Authority* [1989] 2 All ER 545 at 563.

In fact, as early as 1914, the famous American jurist, Cardozo J recognised that:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault.[24]

However, the law recognised certain exceptions to this general rule—particularly as regards persons of unsound mind. The basis for this exception was clarified only early this year by the House of Lords in the case of *F v West Berkshire Health Authority & Anor*.[25] The House of Lords rejected the earlier accepted view that the exception was based on the principle of emergency. It pointed out that: "The principle is one of necessity, not of emergency." [26]

A doctor who assists another without the consent of the latter, will commit no wrong if the assistance is provided in a case of emergency or in a case where a person, because of permanent or semi-permanent inability, becomes incapable of giving consent.

Based on this doctrine, a doctor (or for that matter any other person) who assists another (the assisted person) without the consent of the latter, will commit no wrong if the assistance is provided in a case of emergency or in a case where a person, because of permanent or semi-permanent inability, becomes incapable of giving consent. For example:

> … in a railway accident in which injured passengers are trapped in the wreckage. It is this principle which may render lawful the

24 *Schloendorff v Society of New York Hospital* (1914) 211 NY 125 at 126.

25 [1989] 2 All ER 545, HL.

26 Ibid at 565.

> actions of other citizens, railway staff, passengers or outsiders, who rush to give aid and comfort to the victims; the surgeon who amputates the limb of an unconscious passenger to free him from the wreckage, the ambulance man who conveys him to hospital; the doctors and nurses who treat him and care for him while he is still unconscious. Take the example of an elderly person who suffers a stroke which renders him incapable of speech or movement. It is by virtue of this principle that the doctor who treats him, the nurse who cares for him, even the relative or friend or neighbour who comes in to look after him will commit no wrong when he or she touches his body.[27]

The extent of the assistance would depend on whether the necessity arose from an emergency or from physical inability. In cases of emergency:

> Where, for example, a surgeon performs an operation without his consent on a patient temporarily rendered unconscious in an accident, he should do no more than is reasonably required, in the best interests of the patient, before he recovers consciousness. I can see no practical difficulty arising from this requirement, which derives from the fact that the patient is expected before long to regain consciousness and can then be consulted about longer term measures.[28]

The question as to what a doctor should do when he, in the course of an operation, discovers some other condition which, in his opinion, requires operative treatment for which he has not received the patient's consent—whether he should operate forthwith or should he postpone the further treatment—was left open by the House of Lords. This question, it was admitted was a "difficult matter".

27 Ibid at 566.

28 Ibid.

The Law Lords pointed out that in cases of permanent or semi-permanent disability, there was no need for a doctor to wait for the patient's consent:

> The need to care for him is obvious: and the doctor must then act in the best interests of his patient, just as if he had received his patient's consent so to do. Were this not so, much useful treatment and care could, in theory at least, be denied to the unfortunate.[29]

The House of Lords, however, cautioned that though in such cases, there was no need for the patient's express consent:

> The doctor must act in accordance with a responsible and competent body of relevant professional opinion, on the principles set down in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118, [1957] 1 WLR 582. No doubt, in practice, a decision may involve others besides the doctor. It must surely be good practice to consult relatives and others who are concerned with the care of the patient. Sometimes, of course, consultation with a specialist or specialists will be required; and in others, especially where the decision involves more than a purely medical opinion, an interdisciplinary team will in practice participate in the decision.[30]

Doctors and others involved in the decision-making process should always act in the "best interest of the person".

Furthermore, it was pointed out that the "overriding consideration" is that the doctors and others involved in the decision-making process should always act in the "best interest of the person".

29 Ibid at 567.

30 Ibid.

Over the past two years, the courts have had to battle with the difficult and delicate question as to whether, in the case of a mentally retarded girl or woman who is unable to give a valid consent, abortions or sterilisation may be performed on her. It should be noted that these procedures were deemed necessary, not because of any imminent damage to the health of the girl or woman but because those who had care of her considered the procedures to be in her best interest.

In the much publicised case of *Re B (a minor)*,[31] the court was asked to authorise a sterilisation operation upon a 17-year-old severely mentally retarded girl.[32] The House of Lords gave the consent to the sterilisation as it was clear from the evidence that the girl's "best medical interests" justified the operation.

What then is the position if the girl is no longer a minor but an adult? Again, this question was dealt with by the courts in the recent case of *F v West Berkshire Health Authority & Anor.*[33]

The House of Lords pointed out that under the common law:

> A doctor can lawfully operate on, or give other treatment to, adult patients who are incapable for one reason or another, of consenting to his doing so, provided that the operation or other treatment concerned is in the best interests of such patients.[34]

Any operation or other treatment will be considered to be in the best interest of such persons if the operation or other medical treatment concerned was carried out either to save the lives of such persons or to ensure improvement or prevent deterioration in their physical or mental health. The basis for such a rule is, as I have pointed out earlier, based on the doctrine of necessity.

31
[1987] 2 All ER 206, CA and HL. See Freeman, "Sterilising the Mentally Handicapped" in *Medicine, Ethics and the Law*, Stevens, 1988, pages 55–84 and the cases referred to therein;
Grubb and Pearl, "Sterilisation and the Courts" (1987) 46 CLJ 439–464.

32
The appeal was heard by the House of Lords just a few days before she attained the age of majority.
In this case, as the girl was both a minor and incompetent, she was a ward of the court.
As such, only the court was in a position to give its permission for the sterilisation.

33
[1989] 2 All ER 545, HL.
See the views expressed by Grubb and Pearl, "Sterilisation and the Courts" (1987) 46 CLJ 456–464.
It should be noted that this article was written before the decision of the House of Lords in *F v West Berkshire Health Authority & Anor.*
See also Grubb, "Medical Law" [1988] All ER Rev 206–214.

34
[1989] 2 All ER 545 at 551.

Two further questions arise from this principle of law: first, is the rule applicable also to other treatments which are not necessarily needed for the purposes of improvement of the patient's physical or mental health, eg a treatment for sterilisation; secondly, who decides whether an operation for sterilisation is in the best interest of the person.

In some countries, like the United States, Canada and Australia,[35] the courts have the power with respect to persons of unsound mind to grant permission for such treatment. In other countries, like England, no such power is given to the courts. However, despite the lack of such powers, the English courts have said that:

> Although involvement of the court is not strictly necessary as a matter of law, it is nevertheless highly desirable as a matter of good practice.[36]

Lord Goff, another Law Lord said this:

> The operation of sterilisation should not be performed on an adult person who lacks the capacity to consent to it without first obtaining the opinion of the court that the operation is, in the circumstances, in the best interests of the person concerned, by seeking a declaration that the operation is lawful.[37]

His Lordship then gave the following assurance to the doctors:

> I recognise that the requirement of a hearing before a court is regarded by some as capable of deterring certain medical practitioners from advocating the procedure of sterilisation; but

35
See position in Malaysia under the Mental Disorders Ordinance 1952 and the Courts of Judicature Act 1964 (Act 91, Reprint No 3 of 1988), section 24(d) and (e).
See also Hoggett, "The Royal Prerogative in Relation to the Mentally Disordered: Resurrection, Resuscitation, or Rejection?" in *Medicine, Ethics and the Law*, Stevens, 1988, pages 85–102.

36
Per Lord Brandon in *Re F v West Berkshire* [1989] 2 All ER 545, HL at 552.

37
Ibid at 568.

> I trust and hope that it may come to be understood that court procedures of this kind, conducted sensitively and humanely by judges of the Family Division, so far as possible and where appropriate in the privacy of chambers, are not to be feared by responsible practitioners.[38]

Because sterilisation involves an irreversible interference with the patient's organs which affects "one of the fundamental rights of a woman, namely the right to bear children",[39] the courts take a serious view of the matter—not only for the protection of the woman alone but also for the protection of the doctor—to ensure the lawfulness of the procedure.

Right to know (informed consent)

I now move on to the other issue which I raised earlier: how much of information is a doctor under a duty to disclose to the patient before any medical treatment is undertaken. This is commonly referred to, especially in the United States, as the doctrine of informed consent.

For consent to be effective, it must be voluntary, as well as informed. To be informed, a person needs to know not only about the risks involved in the particular medical treatment but also about alternatives.

Generally, of course, for consent to be effective, it must be voluntary, as well as informed. To be informed, a person needs to know not only about the risks involved in the particular medical treatment but also about alternatives. For example:

38 Ibid at 569.

39 Per Lord Brandon, ibid at 552.

> A woman with breast cancer is entitled to know not only what radical mastectomy may do to her, and its attendant risks, but also that other forms of treatment exist, such as chemotherapy, radiation therapy, or lumpectomy. Without knowing this, she is not sufficiently informed to make a reasoned and comprehending decision. As regards the amount of information the doctor is obliged to give, the ethical principle can only be that she be given that information which she would regard as material in reaching a decision consistent with her views and values.[40]

A compromise has to be struck between "medical paternalism" and "patient sovereignty".

What has been the attitude of the courts towards this doctrine, bearing in mind that the basis of informed consent is a wider ethical aspect of the nature of the relationship between the doctor and patient. As it is said, it is about respect for the person (the patient) and about power (by the doctor):

> It seeks to transfer some power to the patient in areas affecting her self-determination, so as to create the optimal relationship between doctor and patient, which is the same as that between any professional and his client—namely, a partnership of shared endeavour in pursuit of the client's interests.[41]

The basis of the doctrine is that the doctor is ethically bound to disclose all necessary information of a particular treatment so as to allow the patient to make his own decision as to whether he wishes to accept that treatment. However, it is felt that a compromise has to be struck between "medical paternalism" and "patient sovereignty".

40 Kennedy, *Treat Me Right*, page 178.

41 Ibid.

The scope of this doctrine was considered by the House of Lords for the first time in the now well known case of *Sidaway v Board of Governors of the Bethlem Royal Hospital*.[42] The issue which the House of Lords had to decide was spelt out by Lord Scarman in the following words:

> It raises a question which has never before been considered by your Lordships' House: has the patient a legal right to know and is the doctor under a legal duty to disclose the risks inherent in the treatment which the doctor recommends? If the law recognises the right and the obligations, is it a right to full disclosure or has the doctor a discretion as to the nature and extent of his disclosure? And, if the right is to be qualified, where does the law look for the criterion by which the court is to judge the extent of the disclosure required to satisfy the right? Does the law seek the guidance of a medical opinion or does it lay down a rule which doctors must follow, whatever may be the views of the profession?[43]

The House of Lords held that though there was a duty under the law for the doctor to warn his patient of risks inherent in the proposed treatment, and especially so if the treatment is surgery,[44] such a duty as expounded by the American courts was not applicable under English law.

The effect of the decision, therefore, seems to be that the English courts only recognise a qualified right of the patient to be informed. The test they seem to suggest is not whether there has been sufficient disclosure which will be sufficient for the patient to make a decision but whether the doctor had given such relevant information:

42
[1985] 1 All ER 643, HL.
For a critical analysis of the decision of the House of Lords, see Kennedy, *Treat Me Right*, pages 193–212.

43
Ibid at 646.

44
Per Lord Scarman, ibid at 652.

> … in accordance with the practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes a duty of care; but the standard of care is a matter of medical judgments.[45]

The decision of the House of Lords in *Sidaway* has been much criticised.[46] However, the present position appears to be as follows: The doctor must disclose whatever information is requested by the patient, except when the doctor perceives, and if other doctors would perceive similarly, that any such disclosure may not be in the best interest of the patient.

This statement of the law may create certain difficulties for the doctor in determining with any degree of certainty the extent of his legal obligation. This uncertainty however, I may add, is not only faced by doctors but also lawyers who advise doctors—for the truth of the matter is that the law on this point is still unclear.[47]

These are issues which we, particularly as doctors and lawyers, have to face in fulfilling our roles in society—a role which has been placed upon us through trust by the general public. We, therefore, cannot and should not abdicate from these responsibilities.

Conclusion

Many of the legal and ethical issues I have raised so far should not be viewed as issues which are merely restricted to those areas of medical practice alone. These are common issues which are equally applicable to many other areas of medical practice. Within the constraints of time of an oration of this nature this evening, I am

45 The *Bolam* test [1957] 1 WLR 582 as explained by Lord Scarman in *Sidaway* [1985] 1 All ER 643 at 649.

46 See for example Kennedy, *Treat Me Right,* at pages 175 and 194, and [1985] All ER Rev 301.

47 See for example the views of the House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, HL.

unable to discuss other areas of medical practice which are equally important. These issues are now faced not only by the doctors but also lawyers and philosophers—these are much wider ethical and moral issues, issues which we, particularly as doctors and lawyers, have to face in fulfilling our roles in society—a role which has been placed upon us through trust by the general public. We, therefore, cannot and should not abdicate these responsibilities.

Editor's note

Right to know: See also chapter 3, *The Right to Know*, above.