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THE IMPACT OF THE CODE OF HEALTH AND DISABILITY SERVICES CONSUMERS' RIGHTS ON INFORMED CONSENT IN NEW ZEALAND

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ABSTRACT

Informed consent is the primary tool by which the autonomy of the patient and other health consumers is protected in the medical environment. It has been the subject of much attention in the medical and public arena. This was escalated in New Zealand by the Report of the Cervical Cancer Inquiry in 1988 which details many flaws in the processes and protections of informed consent.

Following the recommendations in this report, the Office of the Health and Disability Commissioner and the Code of Health and Disability Services Consumers Rights (the Code) came into existence. Right 6 covers the requisite disclosure of information to consumers.

This paper examines the implications of this Right and places it in context with the common law doctrine of informed consent. The common law has often fallen short of the ideals and purpose of informed consent in its struggle with the competing claims of the medical profession and the focus on compensating for physical injury. Unlike the common law, the Code does not hinge on physical injury, but on the processes of consumer rights. As a consequence it is freed from the bounds of causation.

The Code may also have an impact within the traditional legal forums. A Court considering an action of informed consent should consider the Code as a indication of current social and legislative perceptions about the requirements upon the medical professions.

Of vital importance for this paper is the aim of reconciling the rights of informed consent with the purpose of informed consent.

> Over himself, over his own body and mind, the individual is sovereign
>
> John Stuart Mill

WORD LENGTH

The text of this paper (excluding contents page, footnotes and bibliography) comprises approximately 15328 words.

I INTRODUCTION

> Fairy tales are so appealing because ultimately they reduce complex human encounters to enchanting simplicity. In listening to them we suspend judgment and believe that ... it is possible to utter magic words or perform magic deeds which transform frogs into princes or punish greedy fishermen's wives. The phrase "informed consent" evokes the same magic expectations. Its protagonists often convey that once kissed by the doctrine, frog patients will become autonomous princes. Its antagonists warn that all the gold of good medical care which physician magnanimously bestow on patients will turn to worthless metal if the curse of informed consent were to remain with us.[1]

Although the rhetoric of informed consent is pervasive in the medical setting, actual implementation often falls short of its stated importance. Causation requirements which are inherent in a negligence action, have eroded the doctrine to a duty to warn. This does not reflect the basis of the doctrine which is to safeguard the autonomy of the individual. The arguments of the antagonists are influential in the common law. This is the environment into which the Code of Health and Disability Consumers' Rights (the Code) was introduced. This paper examines the effect that this will have upon informed consent in New Zealand. To do so it must continually be distinguished between the myth and reality.

The ethical basis for informed consent is detailed in Part II. This focuses upon the principle of autonomy. Part III outlines the jurisprudence which exists internationally and domestically. This includes an comparison of the professional focused duty of care and the patient focused standard. In Part IV the Health and Disability Commissioner Act 1995 (HDCA) is introduced. Part V contains an analysis of Right 6. This Right covers disclosure of information generally and for the purpose of informed consent. The writer concludes that Right 6 can be interpreted more widely than the doctrine is interpreted at common law. Having established that this interpretation varies from the international treatments of the doctrine, Part VI questions what impact the Code and especially Right 6 will have on any claims of negligence in the common law. Finally there is discussion of whether the Code can maintain a statutory duty.

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1 J Katz "Informed Consent-A Fairytale? Laws Vision" (1977) 39 U Pitt LR 137, 137.

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II THE ETHICAL BASIS OF INFORMED CONSENT

A Introduction

The development of the doctrine of informed consent has its source in both law and ethics. Each contributes its own initiatives whilst taking note and effect of the contributions of the other. As such it is important to begin a legal analysis of a modern legal development with an examination of the ethical context. The primary ethical source of informed consent in the principle of autonomy.[2]

B Autonomy

Autonomy is a prima facie attribute of all moral agents.[3] It is an attribute which extends to many areas of individual life, of which medicine is only one. Most of the work on autonomy stems from the writings of Immanual Kant and John Stuart Mill. These two philosophers were theoretically approaching autonomy from different angles and as a consequence their interpretations differ.

Kant[4] adopted a deontological perspective. He viewed obligations as independent from individual practical concerns. An action is judged by whether the generalisation which follows from the act is morally good. Thus if what you do does not yield a rule which is acceptable for everyone to follow, it is not morally worthy. He calls this a categorical imperative.

From this he derived the rule that people must be treated as an ends and never a means only. Each individual must have the freedom to pursue their own internal ethical system. Therefore people must treat themselves and therefore all others as ends in themselves.

Mills[5] focused less on the internal beliefs and pursuits of the individual. Instead he determined that as long as the individual has a concept of how to maximise their happiness without infringing upon the similar pursuit of others, the person must be

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2 Autonomy is only one of the four principles which form the principled approach to biomedical ethics espoused by Beauchamp and Childress. The other principles are: non malificence, beneficence, and justice. See T L Beauchamp and J K Childress *Principles of Biomedical Ethics* (4 ed, Oxford University Press, New York, 1994).

3 This section draws primarily from the following sources: P S Appelbaum, C Litz and A Meisel*Informed Consent: Legal Theory and Clinical Practice* (Oxford University Press, New York, 1987) 17-32, T L Beauchamp and J K Childress, above n 2, 56-62.

4 See generally I Kant *Foundations of the Metaphysics of Morals* Trans. L White Beck (New York, MacMillan, 1985).

5 See generally Mill J S, G Himmerfarb (ed)*On Liberty* (Harmondsworth, Penquin, 1982).

free to do so. Thus his focus was upon lack of interference. Mills demonstrates a utilitarian approach where the value of an action is judged by its consequence. For Mills the consequence should be the maximisation of happiness.[6]

C Informed Consent

The need for informed consent follows from the right to autonomy.[7] It is the manifestation of autonomy in the medical setting. For Kant it required that the doctor restrain from coercing the patient, and that they provide them with all the information necessary for rational decision making. Applying the categorical imperative makes this relatively easy to use. The principle must be followed regardless of further considerations.

For a consequentialist the determination is more difficult because many factors may influence the outcome. Examples of factors compiled by Katz and Capron are:[8] individual autonomy, protection of patients and subjects, rational decision making, and medical self-scrutiny. Perhaps the primary conflict facing autonomy in the medical setting is between autonomy and health.[9] This is evident in justifications for ignoring the autonomous choice of the individual and imposing an action which is objectively better for them. Most subsequent debate exhibits this dichotomy.

However although disparity exists, ethical informed consent can still be broadly defined as:[10]

> the core notion that decisions about the medical care a person will receive, if any, are to be made in a collaborative manner between patient and physician.

D Disclosure of Information

Informed consent is a complex procedure. It is best divided into three element.[11] First, the precondition elements of competence and voluntariness. Second, the information elements of disclosure, recommendation, and understanding. Third, the consent elements of decision and authorisation. This paper focuses only on the element of

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6 This goal labels Mill as a hedonist utilitarian. Other examples of utilities are: knowledge, health and understanding. Above n 2, 48.

7 Above n 3, 26-28.

8 J Katz and A M Capron *Catastrophic Diseases: Who Decides What?* (Russell Sage Foundation, New York, 1975)82-90.

9 Above n 3, 28-31.

10 Above n 3, 12 quoting Katz.

11 Above n 2, 145-146.

information disclosure. Although Right 6 also covers informed consent in relation to research, this will not be considered in this paper as it is a vast issue on its own.[12]

E Summary

The impetus for the law on informed consent is the autonomy of the individual. Undoubtedly this impacts on health professionals and the community however this consideration must remain secondary. Autonomy must be the foremost measure against which actions implementing informed consent are assessed

III JURISPRUDENCE ON INFORMED CONSENT

A Introduction

When the Code came into operation on 1 July 1996 it was not born into a vacuum. This section of this paper examines the legal context in relation to informed consent of which the Code now forms a part for New Zealand health services consumers. It is important to recognise the strengths and weaknesses of this system thus allowing the full implications of the Code to be measurable.

B New Zealand Law

Due to the bar on civil claims for personal injury under the various ACC Acts[13] *Smith v Auckland Area Health Board* [14] is the only New Zealand case law on point. In *Smith* the judge was careful not to decide on the doctrine of informed consent except as it related to specific questions. Therefore it is necessary to look beyond New Zealand for a legal context.

C International Law

The doctrine of informed consent is a negligence action. Therefore the necessary elements of liability are the establishment of a duty of care, breach, causation, and damage. The legal consideration of informed consent concentrates primarily on two of these elements. The initial enquiry establishes the standard of care owed to the patient, this is followed by a determination of whether the breach of the duty was the cause of

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12 See discussion in D Collins *Medical Law in New Zealand* (Brooker and Friend, Wellington, 1992), ch 4.

13 See discussion below part III D.

14 [1965] NZLR 191 (CA).

the subsequent damage. There are two lines of international jurisprudence in the resolution of these issues. They revolve about the distinction between a doctor focused approach and a patient focused approach. The following section of this paper outlines the development of the common law internationally and some of the critical issues this uncovers. Other criticisms of the doctrine exist, however these will be discussed later in the paper as they relate directly to the Code.

1 Professional focus: Establishing the duty of care

(a) Overview of the law

Bolam v Friern Hospital Management Committee[15] set the precedent for the English standard of disclosure. McNair J stated that a doctor "is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that particular art"[16]. The House of Lords endorsed this in *Sidaway v Royal Bethlem Hospital Governors*.[17] Concisely stated the "law imposes the duty of care, but the standard of care is a matter of medical judgment".[18]

The majority of Law Lords reserved a role for the Court in appraising the situation, even if it complied with the opinion of a "reasonable body of medical men". This was for the Court to conclude upon hearing the doctors evidence if the test was fulfilled. However, this would only override a doctor's professional assessment if the undisclosed risk was substantial and with "grave adverse consequences"[19]. Unfortunately this potential was quashed by subsequent interpretation in *Gold v Haringey Area Health Authority*.[20] It was held that determination of the appropriate disclosure requirement is solely the role of the medical profession and not something that the Court can hold a contrary opinion on.[21]

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15 [1957] 1 WLR 582; [1957] 2 All ER 118. For future references only the WLR report will be referred to.

16 Above n 15, 587.

17 [1985] 1 AC 871; [1985] 2 WLR 480; [1985] 1 All ER 643 (HL). For future references only the AC report will be referred to.

18 Above n 17, 881.

19 D Giesen and J Hayes "The Patient's Right to Know- A Comparative View" (1992) 21 Anglo-Am LR 101, 103.

20 [1988] QB 481; [1987] 3 WLR 649; [1988] 2 All ER 888. For future references only the WLR report will be referred to.

21 Above n 20, 657.

(b) Regulation of medical practice

These English cases reflect the value placed upon the doctor's duty to act in the best interests of the patient. Following this at the expense of patient autonomy indicates a paternalistic attitude which places recovery primary in the hands of the medical profession.

The doctor focused standard is proposed as the most appropriate for the regulation of medical practice. There is validity to the claim that when judicial comment provides any internal regulation this goal is best served by a doctor focused test. This allows the profession to ensure that there is unified compliance with appropriate standards because they determine what the appropriate standards should be. The reality of a patient focused test is that "one can not know with certainty whether a consent is valid until a lawsuit has been filed and settled."[22] Potentially this can undermine the regulatory value as pursuit of an established standard will not protect practitioners and concrete guidelines can not be given.

However it is necessary to ask if this is the purpose of the disclosure requirements. Judicial comment in other jurisdictions proposes that this is the role of internal disciplinary bodies and societies, and not the role of a Court considering the doctrine of informed consent.[23]

> The issue under consideration is a different issue than that involved where the question is whether the doctor carried out his professional activities by applicable professional standards. What is under consideration here is the patient's right to know what risks are involved in undergoing or foregoing certain surgery or other treatment.

Informed consent in negligence actions is for the purpose of protecting individuals from violation. Impetus for the action lies with the complainant, not the good name and consistency of the medical profession.

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22 J F Merz "On a Decision-Making Paradigm of Medical Informed Consent" (1993) 14:2 Journal of Legal Medicine 231 241, quoting *Moore* v *Regents of the Univ. of California* 51 Cal. 3d 120, 165 n. 41.

23 For example see *Reibl v Hughes* (1980) 114 D.L.R 1, 13.

(c) Impediment to medicine development

As reasoned in *Sidaway*, a doctor focused approach allows for the development of medicine. This implies that disclosure may result in the refusal of treatment. Following this argument through it is difficult to avoid the conclusion that the doctrine of informed consent is being used as a limb of experimentation. As the extensive medico-legal material on clinical experimentation evidences, this is a contentious area.[24]

Again underlying this is a conflict of interests. Informed consent is primarily a right of autonomy, where "every human being of adult years and sound mind has a right to determine what shall be done with his own body..."[25] and where the physician's duty is to the patient to disclose material risks.[26] Any duty to medical advancement must be secondary to the individual right of the patient when they may conflict. Discussed later is the absolute right to refuse medical treatment in the New Zealand Bill of Rights Act 1990, this is relevant as it indicates the prioritisation of individual rights above benefits of medical development.[27]

(d) Professional interests

Underlying the doctor focused approach is a confidence in the medical profession's concern for the patient. This assumption was questioned in the US and Australian cases. King C J was influenced by this in *F v R* stating:[28]

> Practices may develop in professions, particularly as to disclosure, not because they serve the interests of the clients, but because they protect the interests or convenience of members of the profession.

Judicial acknowledgement of this bias highlights the realities which should be borne in mind when considering what the focus of the standard of negligence should be.

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24 Above n 12.
25 *Schloedorff* v *Society of New York Hospital* 211 N.Y. 125, 105 N.E. 92, 93 (1914).
26 Above n 23, 5.
27 See below part V B 2.
28 *F* v *R* (1984) 33 SASR 189, 194.

2 *Patient focus: Establishing the duty of care*

(a) Overview of the law

Alternatively, the requisite disclosure is measured by the requirements of the patient instead of accepted medical practice. An objective standard is the usual tortious test for the reasonable duty of care one person owes to another. This is tempered in application by the particular circumstances of the case including special knowledge that the defendant may have.[29] Objectivity is the undisputed standard on which the doctor is judged, however debate reigns over the informational requirements which the reasonable doctor must provide.

A line of cases stemming from *Canterbury v Spence*[30] affirm the dominance of the mythical "reasonable patient" in informed consent.[31] Information about a risk is:[32]

> [M]aterial when a reasonable person in what the physician knows or should know to be the patients position, would likely attach significance to...in deciding whether or not to forgo the proposed therapy.

The test still asks what the reasonable course of action was for the doctor, but what is reasonable is measured in light of the requirements of the reasonable patient. Whether this occurred at law is to be determined by the legal fact finder. They must determine whether disclosure was adequate, and if it was not, they must determine whether liability should be imposed or if the suppression was morally justifiable.[33]

In *Reibl v Hughes*[34], the Canadian Supreme Court held that materiality is to be measured against all the circumstances of the case. Such an assessment was for the Court to make and was not concluded by the opinion of the medical profession. Medical evidence has an evidential role in this balance however it is not conclusive.[35]

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29 S Todd (ed) *The Law of Torts in New Zealand* (The Law Book Cmp Ltd, Sydney, 1991) 259.

30 464 F2d 772, (DC Cir 1972).

31 Above n 28, 192.

32 Above n 30, 787.

33 It may be justified under professional privilege. For a discussion of this see I Kennedy and A Grubb *Medical Law: Text With Materials* (Butterworths, London, 1994) , 211-215.

34 Above n 23.

35 The facts in this case clearly involved a material risk. The chance or a stroke or worse resultant from the procedure were at least 10%. The patient was aware only that he would be better off with surgery than without it, this presumption was not established by the facts.

A considerable step was taken towards subjectivity in the recent Australian case *Rogers v Whitaker*[36]. Included in the factors that a physician should evaluate is the significance that the "particular patient" may attach to a risk if warned of it. This particular patient is unrestricted by requirements of reasonableness. Reiterating parts of *F v R*, the Court held that: the desire of the patient for information, the temperament and health of the patient, and the general surrounding circumstances were all relevant to the evaluation.

The High Court of Australia in *Rogers* has individualised this further than in *F v R* by measuring "material" by both the reasonable person and the particular patient. The complainant who was blind in one eye and was especially concerned about her good eye being protected when her blind eye was operated on. Although she did not specifically question the risk to her remaining sight, she extensively queried the general risks. This affected the standard of disclosure owed to her. The Court held that this made the doctor aware of the significance this patient attached to the risk.[37] Although discussing the fact that this was relevant to the particular patient, the case was decided in accordance with the reasonable patient test. It was considered that the remaining sight would be material to a reasonable person in the complainant's situation. Therefore the use of the "particular patient" limb remains unclear. However it does indicate that in Australia, judicial attitude is open to a subjective standard

3 *Patient focus: Establishing causation*

(a) *Overview of the law*

Causation is an essential element of tortious liability. Since *Canterbury*, it was required that the withheld information would have resulted in the damaging treatment being declined . In both *Canterbury* and *Reibl* this was asserted as an objective test. The doctor is negligent only if the reasonable *patient* would have declined treatment if the risk was revealed. To mitigate the harshness of this the patient should be a reasonable patient in the position of the actual patient. Although subjective approaches have been suggested, they have been rejected on policy

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36 (1992) 175 C.L.R. 479. There is evidence of a subjective standard in some European case law, especially in Germany and Switzerland where patients retain their "absolute discretion" even if it is unreasonable, untenable or inappropriate. See D Giesen *International Medical Malpractice Law: A Comparative Law Study of Civil Liability Arising From Medical Care* (Martinus Nijhoff Pub, Dordreht, 1988) 110-122.

37 Above n 36, 487.

grounds. Subjective standards are thought to expose the doctor to the hindsight of an injured person.[38]

It is at this point that *Rogers* diverges markedly. The patient's subjective evidence as to the effect that the information would have had on her decision was accepted. It was held that this evidence is subject only to the Court's belief in its truthfulness and not its reasonableness.[39]The causation issue was dealt with by the trial judge who found credible the complainant's evidence that she would not have undertaken the surgery if the risk to her good eye had been disclosed. This finding was affirmed in the NS Supreme Court.[40] The High Court did not consider it. Thus the Australian position on causation is subjective.

(b) Difficulties in separating materiality and causation

Imposing an objective test at the point of causation can vitiate the finding of materiality. This occurs for two reasons.

First, it is difficult to assess what the reasonable patient would have done. Physicians suggest certain procedures as they believe them to be the best option, as the people with the most expansive medical knowledge, their opinion as to what the reasonable cause of action was has substantial influence on determining what would have been medically reasonable in law. The claimant has a high burden to discharge to demonstrate why he or she would have *reasonably* chosen another option, contrary to medical opinion.

Interestingly, the Canadian Courts are applying this test in an manner which further devalues the specific patient. Conclusions are often drawn that a reasonable patient with trust and confidence in their doctor would likely have followed their advice anyway.[41] This is inconsistent with the policy in *Reibl.* In cases of non malicious suppression, this begins to look similar to "good medical practice", the professional focus test the court was rejecting.

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38 Above n 23, 16.

39 The more reasonable the belief the easier it will be to discharge the evidential burden.

40 *Rogers* v *Whitaker* [1991] 23 NSWLR 600, 619.

41 Merz J F and G Robertson "Informed Consent Ten Years Later: The Impact of Reibl v Hughes" (1991) 70 The Can Bar R 423, 433-434.

In addition, evidence points to patients misunderstanding the options and risks explained to them.[42] This affects their ability to make an objectively reasonable decision. The writer queries whether other lay people, importantly juries and judges, are sufficiently devoid of these difficulties to enable them to assess what the reasonable course of action was. In demanding an objective test the Courts are demonstrating a belief in objectively correct responses. Patients do not necessarily think in this way. Neither do juries and judges. There is an element of myth making in this enquiry.

Second, fundamental to a finding of materiality is acceptance that the information is reasonably significant to the patient. To be significant the information must surely be something that they consider useful in the task of assessing their options and the decision they must make. Information withheld from a patient must therefore be information of this type to be considered material. Thus considerations of whether the undisclosed information would have influenced the patient's decision to undergo the procedure that caused them injury has already been answered under the first limb. The need to readdress this in terms of causation produces the effect of having the Court look for evidence of extra reliance on the non disclosure than is necessary. As a result material information which the patient may be deemed to have the legal right to may not be enforceable because the reasonable patient would not have declined the treatment on that basis.[43] This is the way the jurisprudence in the area has operated. Twerski and Cohen noted:[44]

> [T]he combined effect of the standards of disclosure and causation is that, for all practical purposes, a patient is only entitled to information which would lead a reasonable patient to choose against the doctor's recommended therapy.

Again this begins to look similar to the good medical practice test rejected in *Canterbury*.

D Negligence in New Zealand and The Accident Compensation Scheme

Negligence in New Zealand is pursuable primarily through the Accident Compensation Corporation scheme (ACC), because s 14 of the ARCIA currently bars

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42 Tweski A D and N B Cohen "Informed Decision Making and the Law of Torts: The Myth of Justiciable Causation" [1988] U Ill L Rev 607, 626. This article outlines some of the logical errors patients make in assessing information they are provided with.

43 Above n 22, 250 and 254.

44 Above n 42, 615.

civil actions for injury covered by the Act. As discussed below this covers negligence in the area of informed consent. However the bar is such that in there may be scope for civil action in cases where there is no physical injury, such as where the damage is mental or economic. On occasion there may also be actions for exemplary damages. This is to "punish the defendant for high handed disregard of the plaintiff's rights or the like outrageous conduct".[45] Still, most informed consent considerations in New Zealand have been within the ACC arena.

1 The Accident Compensation Acts of 1972 and 1982

Although the original wording of the 1972 Act did not directly refer to medical misadventure, this was amended before the Act came into operation. Section 8 stated:

> Personal injury by accident-
>
> (a) Includes-
>
> (ii) medical, surgical, dental, or first aid misadventure.

This provision was continued without alteration in the 1982 Act. For this period the legal debate revolved around the existence of medical misadventure.[46]

Up until 1990 the Accident Compensation Appeal Authority (ACAA) refused to accept that medical misadventure could be found solely for examples of informed consent. In *Gosling v ACC* [47]it was queried whether an eventuated risk that was too common to constitute misadventure should become misadventure because of lack of informed consent. The authority had difficulty accepting that it should.

However it is now clear that negligence does fall within medical misadventure.[48] Thus it is under this head that informed consent was pursued with more success following 1990. The leading case is *H v ACC*.[49] The ratio statements in that judgment affirmed the decision in *Smith v Auckland Area Health Board* that there is a duty of due care upon the doctor to answer an express question from the patient. This had been widely accepted prior to this judgment, however it was the obiter statements with regard to a wider duty which were important. The Court held that a prudent gynaecologist would

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45 See *Donselaar v Donselaar* [1982] 1 NZLR 97. *Green v Matheson* [1989] 3 NZLR 564.

46 See generally Collins above n 12, 54-57,141-160, and M Vennell *Informed Consent or Reasonable Disclosure of Risks: The Relevance of an Informed Patient in the Light of the New Zealand Accident Compensation Scheme* [1987] NZLR 160.

47 [1990] NZAR 76.

48 See *Re P* ACAA Decision 2/89, *Polansky v ACC* [1990] NZAR 481, and Collins above n 12, 145-146.

49 [1990] NZAR 289.

have warned the patient of the risk of the sterilisation operation failing. The test adopted was that in *Sidaway*. This case has subsequently been affirmed.[50]

In the 1993 case *Smith v ACC*[51], the courts laid out the elements for an action in informed consent in that case. Stating:

> In order to establish medical misadventure through lack of informed consent the appellant must show:
>
> 1 Either that a *duty of care* was owed by the doctor to inform the appellant before the operation of the possibility of failure and that the doctor was in *breach of that duty*, or
>
> 2 There is a duty upon a doctor to use care in answering questions put to him or her when the doctor knows that reliance is being placed on that answer, and the doctor has breached that duty.
>
> 3 And in addition to proof of a duty of care and a breach of that duty, the appellant must persuade, on the balance of probabilities, that the *damage suffered*,...is *casually connected* with the breach of duty. (emphasis added)

All the elements of the tort of negligence were required. In this case the breach of duty was not at issue because the judge was unable to accept the evidence that the patient was not informed of the risk. Thus nothing was said to alter the applicable test from *Sidaway*. However it was the consideration of causation which is of most interest. In the alternative the judge concluded that there was no proof that the patient would have forgone the treatment even if disclosure had been made. In a memorandum to the parties concerning the decision he wrote:[52]

> I am also in some doubt that Mr Smith would not have undergone the procedure as he has unfortunately suffered from ear problems for at least part of his life and I would consider that he would, *being a prudent person, follow specialist medical advice* in an endeavour to remove his ear problem. (emphasis added)

This is similar to some developments in the Canadian law,[53] and it highlights the difficulties that a doctor focused test has in affirming the autonomy of the individual.

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50 For example see *Hazel v ACC* [1991] NZAR 362 and *Davie v ACC* [1993] NZAR 1.
51 [1993] NZAR 490.
52 Above n 51, 491.
53 See above part III C 3 (b).

2 *Accident Rehabilitation and Compensation Act 1992*

The Accident Rehabilitation and Compensation Act 1992 (ARCIA), s 5 (6) provides:

> A failure to obtain informed consent to treatment ...is medical misadventure only if the registered health professional acted negligently in failing to obtain informed consent.

There is no practical difference between this and the test applied under the earlier Acts. They were focusing on a duty of care, that duty being the gatekeeper of a negligence action.

There have been no reported cases on informed consent under this Act.

3 *Summary*

ACC has restricted the development of common law in New Zealand. However negligence is in fact necessary to qualify under the scheme. As such it has evolved its own jurisprudence, which so far has reflected the professional focused test.

E Conclusion

There is a clear division between the North American/Australian approach and the English approach. The former focuses upon the needs of the patient, with further debate about the degree of subjectivity allowed, whilst the later focuses upon the reasonable actions of the doctor according to his or her peers. Prior to the inception of the HDCA and the Code, New Zealand was free to follow either the approach. Although the Judge, now Justice Cartwright, encouraged the later in her report into the treatment of Cervical Cancer at National Women's Hospital (the Cartwright Report):[54]

> I consider that the New Zealand Courts, if they had been freed from the constraints imposed by the Accident Compensation Act 1972 and its amendments, would be more likely to follow the Australian example...The focus should be centred on the patient's rights and not to protect the doctor from liability.

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54 *The Report Of The Committee Of Inquiry Into Allegations Concerning The Treatment Of Cervical Cancer At National Women's Hospital And Into Other Related Matters* (Auckland, 1988) 136.

This is also the approach of the Medical Council who require that the information disclosed should reflect what a prudent patient in that patient's situation would expect, and more specifically the actual knowledge of the patient and the practitioner.[55] This approach is more consistent with the autonomy of the patient. However both approaches have fallen short of providing the individual with sufficient information to effect a fully considered decision.

IV HEALTH AND DISABILITY COMMISSIONER ACT 1995

A Background

In 1988 the now Justice Cartwright, presented her report on the treatment of cervical cancer at National Women's Hospital. Included in her recommendations and findings were the suggestions that a statement of patient rights should be implemented and a health Commissioner established. She envisaged the Commissioner's role to include; negotiating and mediating over complaints, heightening professional understanding of patient rights and the provision of rulings and sanctions.[56] This report that was the main impetus for the HDCA.[57] The purpose of the Act is to promote and protect the rights of health and disability services consumers, and, to that end facilitate the fair, speedy and efficient resolution of complaints relating to infringement of those rights".[58]

B Introduction to the Code Of Health And Disability Services Consumers' Rights

Central to the operation of the HDCA is the Code Of Health And Disability Services Consumers' Rights (the Code). It is a breach of the Code which the redress procedures set out to remedy. The first priority of the Health and Disability Commissioner was to prepare a draft Code in accordance with the requirements of ss 19 and 20 of the Act. This procedure was begun in 1995 and consisted of two rounds of consultation and preparation of draft Codes. On 1 July 1996 the final Code came into effect. It is contained in regulations to the Act.[59]

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55 Above n 12, 59-60, and Medical Council of New Zealand *A Statement for the Medical Profession on Information and Consent* (Wellington, 1995). See discussion below part V D 3 (a).

56 Above n 54, 214.

57 (1994) 543 NZPD 4299, the Hon Katherine O'Reagan on the third reading of the Bill.

58 Health and Disability Commissioner *Draft Code of Health and Disability Consumers' Rights* (Wellington, 1995).

59 Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

C *Operation of the Act*

Resolution of disputes for a breach of the Code is available at five levels.[60] Consistent with the desire to resolve disputes at the lowest level possible, these options are largely progressive, although complaints can be instigated with the advocate or Commissioner[61] and instigated by the Commissioner herself[62].

These levels are as follows:

- Level 1. Self advocacy using the Code as a tool.
- Level 2. Advocacy assistance either to approach the provider or to make a complaint to the Commissioner.[63]
- Level 3. Commissioner to decide whether to pursue the complaint, and if so to investigate whether it constitutes a breach of the Code.[64] Disciplinary bodies may be notified.[65]
- Level 4. Further option of referring to advocacy.[66]
- Level 5. Complaints Review Tribunal hearing,[67] where a wide range of remedies may be sought. These include: declarations, restraining orders, damages, performance to redress loss or damage, or, other relief as the Tribunal sees fit.[68]

V THE OPERATION OF INFORMED CONSENT WITHIN THE HEALTH AND DISABILITY COMMISSIONER ACT 1995

A *Introduction*

The following section provides an interpretation of Right 6 drawing from a combination of common law, specific statutory enactments and the principles which found informed consent.

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60 (1994) 543 NZPD, 3735. As stated by the Hon. K O'Reagan, then Assistant Minister of Health.
61 HDCA s 31.
62 HDCA s 35 (2).
63 HDCA s 30 (i).
64 HDCA s 36.
65 HDCA s 38.
66 HDCA s 42.
67 HDCA s 50.
68 HDCA s 54.

Right 6 lends itself to be examined in parts, however in doing so the whole must be kept in mind. No Right or portion of a Right exists which does not impact on the rest. Reading Right 6 this way provides avenues for the consumer to attain a level of autonomy not effected by the common law doctrine of informed consent. Where previously the rhetoric of informed consent has dominated the doctrine, the Code allows the real implementation.

B "Reasonable Consumer in that Consumer's Circumstances"

1 Background

The "reasonable consumer in that consumer's circumstance" is the focal unit for Right 6. It is used as a gatekeeper in both Right (1) and (2). When the term was introduced to Right 6 (1) of the Code, "in that consumer's circumstance" was described as the element through which the information can be "tailored" to the individual needs of the patient.[69] This description does not mirror the meaning of this phrase in at common law. Whilst still connected to a standard that incorporates the reasonable consumer, the consumer remains a generalised image of the particular patient.

However expanding the test to a "reasonable patient in that patient's circumstances" has allowed the Courts scope for looking at individual requirements. For example, in *Reibl* the complainant had to acquire another year and a half of experience at his workplace to qualify for a life pension. The Court considered this relevant to the disclosure owed to him, especially since there was no immediate need for the surgery to be performed before this period elapsed. This still falls below the particular patient test. It still requires the information to be reasonable.

2 Inconsistencies between the right to refuse medical treatment and the right to adequate information

The New Zealand Bill of Rights Act 1990 (the Bill of Rights), s 11 affirms the right to refuse medical treatment. This is repeated in Right 7 (7) of the Code. Neither provision imposes any duty to exercise this right reasonably. This affirms the position at common law.[70] Most competent adults[71] are free to refuse medical intervention on purely subjective grounds. As stated in *Smith*:[72]

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69 Office of the Minister for Health: Media release *Amendments to the Draft Code of Health and Disability Services Consumers' Rights* (Wellington, 30 April 1996), 3.

70 Above n 14, 191, and *Re S* [1992] 1 NZLR 363 for comment on the Bill of Rights affirming the common law. For examples of common law see; *R v Blaue* [1975] 1 WLR

> An individual patient...must always retain the right to decline operative investigation or treatment however unreasonable or foolish this may appear in the eyes of his [or her] medical advisors.

In *Malette v Shulman*[73] the complainant was brought to hospital unconscious following a car accident. She was carrying a Jehovah's Witness card stating that she refused blood transfusions under all circumstances. The doctor, unsure of his obligations in the circumstances, proceeded with the transfusion necessary to save her life. As a consequence he was sued and had damages awarded against him. In the judgment the Court stated that the doctor had no right to assess the reasonableness of the refusal as long as the instruction were clear. It is implicit that the refusal is not one that the Court or doctor would consider reasonable in those circumstances. Thus the beliefs of the complainant were protected by the subjective nature of the right to refuse treatment.

However consider a situation where the consumer is a Jehovah's Witness. The doctor is aware of her religion but nothing had been said or asked about blood products. There is a very small risk that the procedure being most seriously considered may require a blood transfusion. The chance is so minimal and so easily remedied that disclosure would not normally be expected. The risk transpires and as a result of the person's refusal they are injured. The Court considering whether the disclosure of information was adequate would have to ask if the *reasonable* consumer in that consumer's circumstance would have attached significance to the risk sufficient to render it material. It would be inconsistent for the Court to define a belief that they label unreasonable in relation to refusing treatment, as reasonable for the purposes of disclosure.

Therefore transposing current legal definitions into the Code will render Right 6 inconsistent with the subjective right in s 11 of the Bill of Rights. It could result in a subjective right to refuse a procedure, but only an objective right to know that it could be a choice you may have to make. Without this information the consumer can not fully assess their options.

1411, *Re T (adult: refusal of treatment)* [1992] 4 All ER 649, *Re W (a minor)* (medical treatment) [1992] 4 All ER 627, (all Jehovah witness cases).

71 There are examples of this being overridden if the patient is pregnant. See above n 33, 342-400. This is an issue in the UK at present following two publicised examples of women being subject to caesarean despite their refusal of the procedure. These have been situations where the women have not been mentally disordered, but where the child would be endangered by natural birth. See discussion of this in B Hewson "Women's Rights and Legal Wrongs" [1996] New Law J 1385.

72 Above n 14, 191.

73 (1991) 2 Med LR 162.

The Bill of Rights provides a tool for the Commissioner to develop the Code to remedy this inconsistency. The phrase "reasonable consumer in that consumer's circumstance" is far from clearly expressed. If a statutory provision can be read consistently with the Bill of Rights, s 6 requires that it must be. As Rishworth noted:[74]

> Wherever there is the possibility of reading down [the Bill of Rights], the Court is faced with more than one possible meaning. An interpretative choice must be made, and the mandatory instruction in s 6 applies: the Court "shall prefer" the consistent meaning.

When legal focus is on the consumer's requirements as it is in the rest of the Code, then they are entitled to information to furnish this decision. The phrase "reasonable consumer in that consumer's circumstance" can be read consistently with this, by rendering it consistent with s 11 of the Bill of Rights.

The writer argues that "reasonable" could be interpreted as a responsibility on the consumer to alert the doctor to their particular concerns. This is completely different from a value judgement on the reasonableness of those concerns. If defined this way there exists no impediment to imposing a subjective standard into the Code akin to the particular patient focus in *Rogers*.

This argument is more consistent with the purpose of the Code and the other provisions than the meaning given in the case law . Right 4 (3) ensures the right to services of an appropriate standard and provides:

> (3) Every consumer has the rights to have services provided in a manner consistent with his or her needs.

"Services" is defined in reg 4, to include health care procedures. Right 4 (3) is clearly subjective and imposes a duty on the provider to regard the patient as an individual and to provide for them as such. This is further guaranteed in Right 3; the Right to Dignity and Independence. Right 5 (2) encourages an environment where the consumer can

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74 G Huscroft and P Rishworth *Rights and Freedoms: The New Zealand Bill of Rights Act 1990 and The Human Rights Act 1993* (Brooker's, Wellington, 1995) 107. See also *Knight v Commissioner of Inland Revenue* [1991] 2 NZLR 30, at 43.

communicate freely. Ideally this will enable consumers to bring their particular circumstances to the notice of the health provider. If this occurs there is no need for the imposition of any objective test. The doctor will not be required to read the patient's mind as communication between them will be sufficient to inform him or her. Further the patient is required to act reasonably towards the provider which will necessarily involve the disclosure of adequate information for their particular concerns to be obvious. This is a lower test than requiring direct questions. Asking the right questions often involves a level of knowledge that the consumer does not have. If this still looks to subject the provider to excessive disclosure, Right 10 (3), the defence of resource and clinical restraints can be utilised.

Therapeutic privilege need not be affected by this interpretation because Right 10 (3) allows for defences when clinical circumstances requires.

Therefore, Right 6 should be interpreted as subjectively as statutory interpretation allows. The writer argues that this can be an extremely subjective approach. The remainder of this section involves an analysis of the rest of Right 6. For these discussions the interpretation of "reasonable" consumer is not the focus, instead the focus is upon the specific types of information that must be disclosed. Under either interpretation, the Code takes the rights of the health services consumer beyond the common law.

C Right 6 (2): The Right to Informed Consent

> (2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstance, needs to make an informed choice or give informed consent.

1 Relationship with the doctrine of informed consent

Right 6 (2) sets the standard of disclosure of information for the purposes of informed consent. This is the only provision that refers directly to the requisite standard of disclosure for this purpose. The provision refines the requirements to that which are necessary to "make an informed choice or give informed consent". The definition of this phrase is not developed within the Code. The drafters made it clear that this was worded to "enable the detail of what is required to evolve and develop over time"[75].

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75 Health and Disability Commissioner *Draft Code of Health and Disability Services Consumers' Rights: Consultation Summary* (Wellington, 1995) 33.

Ostensibly, the Commissioner is constrained by Right 7 (1) which links Right 6 (2) to the common law:

> (1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, *or the common law*, or any other provision of this Code provides otherwise. (emphasis added)

This appears to introduce all the defences that the common law provides against a claim of inadequate disclosure. This could equate to invoking the common law tests if these are lower than the standard in the Code. However the writer argues that this overstates the importance and intent of this provision. Right 7 is intended to cover situation where consent is unnecessary and not situations where the information that needs to be disclosed is questioned. The Commissioner clarifies her intention in the commentary to Right 7 in the first draft, "the issue of what "informed" means is dealt with in Right 6"[76].

In the first draft the exceptions listed in Right 7 (1) were restricted to statutory enactment or the doctrine of necessity. It was suggested that the doctrine of necessity should be allowed to develop in line with the common law.[77] It appears that the extension of Right 7 (1) from statutory law to common law was made with this in mind.[78] A wider consequence was not intended.

Alternatively, it can be argued that the meaning of the term "common law" is ambiguous. The common law provides no definitive answer with regards to information disclosure.[79] Therefore defining which line of cases to implement under Right 7 (1) is a question of statutory interpretation. This will invoke the Bill of Rights.[80] It will also require the provision to be interpreted consistently with the rest of the Code, especially those which encourage a personalised view of the consumer and their needs. Both these factors skew the relevant common law in favour of the subjective interpretation in *Rogers*.[81] The Commissioner will only be restricted by the interpretation given to the "reasonable consumer in that consumer's circumstance".

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76 Above n 58, 35.

77 Above n 75, 37.

78 See Correspondence from P Skegg to K Poutasi concerning the Draft Code of Health and Disability Services Consumers' Right 12 December 1995, Ministry of Health file AD10-23-5#2. referring to the Consultation Summary above n 75,37.

79 See above part III C.

80 See above part V B 3.

81 See above parts III C 2 (a) and III C 3.

2 *The placement of the provision*

The primacy of this provision is disguised by its placement as following Right 6 (1). The Ministry of Health was advised that the order should be reversed.[82] This did not eventuate. The effect is that Right 6 (2) appears to be the safety net that follows Right 6 (1) and the specific examples of information that should be disclaimed to consumers.

Another suggestion was merging the provisions. The first Cabinet Social Policy Committee paper actually did so stating that:[83]

> (6)(a) Before making a choice or giving consent, every consumer has the right to receive the information needed by a reasonable consumer, in that consumer's circumstance, to make an informed choice or give informed consent, including—

This suggestion was strongly opposed by the Commissioner who argued that it undermined the wider scope of Right 6 (1).[84] Relating Right 6 (1) to informed consent eliminates its operation in situations where a choice is not being made. The Commissioner always intended Right 6 (1) to extend to all consumers and not just those making a choice. In this correspondence she gave the example of consumers who are not capable of giving consent on their own behalf such as children or those with intellectual handicaps, but who are entitled to the information. The merger was abandoned and the provision enacted in its present form.[85]

This will affect the way that the Code influences informed consent in New Zealand because Right 6 (1) is the leading enactment for the disclosure of information to health services consumers.

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82 Correspondence from R Paterson to K Poutasi concerning the Draft Code of Health and Disability Services Consumers' Right 19 December 1995, Ministry of Health file AD10-23-5#2. Correspondence from P Skegg to K Poutasi concerning the Draft Code of Health and Disability Services Consumers' Right 12 December 1995, Ministry of Health file AD10-23-5#2. Correspondence from Crown Law Office to H Lockyer concerning the Draft Code of Health and Disability Services Consumers' Right 16 January 1996, Ministry of Health file AD10-23-5#2.

83 Cabinet Social Policy Committee *Draft Code of Health and Disability Services Consumers' Right: Proposed Amendments*, 12 S P C (96) (Wellington, 19 February 1996).

84 Correspondence from R Stent, Health and Disability Commissioner to H Lockyer, 27 February 1996, Ministry of Health file AD10-23-5#4.

85 Cabinet Social Policy Committee *Draft Code of Health and Disability Services Consumers' Right* , S P C (96) 19 (Wellington, 4 March 1996).

D *Right 6 (1): The right to disclosure of information: Drafting history*

> (1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstance, would expect to receive, including—

Right (1) specifically requires that all consumers have the right to information that the reasonable consumer in that consumers circumstances would expect to receive. This includes an explanation of the options available, an assessment of the risks, side effects, benefits and costs. It extends to consumers who are not being asked to make a choice. Right 6 (1) is intended to set up a minimal set of information which the consumer is entitled to by virtue of being a consumer and not by virtue of being required to exercise a choice.[86]

However the information listed in Right 6 (1) is primarily of the kind that someone exercising informed consent would expect to receive. Thus Right 6 (1) is practically about informed consent, but in strict terms the breach of this provision would constitute a breach of the rights of disclosure and not a breach of informed consent requirements under the Code. This may protect it from interference from the common law under Right 7 (1).

The details of this provision are further complicated by the addition of the reasonable person standard in the final Code. This is different from the wording of the final draft. The final draft proposed that the information required by right 6 (1) would be an absolute *minimum* package for all consumers, stating, "Every consumer has the right to receive without asking—".[87] This was not a disclosure fettered by a test of reasonableness.

Therefore worded this way, Right 6 (1) can not have been intended to reach as widely as the requirements of informed consent. It would be nonsensical to require that all consumers are entitled to all the information about the procedure that is listed. Any study of the case law on informed consent would have illuminated the distance between the common law and this standard.[88] Because the actual scope of this information was left open, the Court would have had to interpret it in context,[89] with the context revealing its practical limitations. This is further evidenced by the existence

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86 Above n 75, 33.
87 Above n 75, 33.
88 See above Part III C.
89 J F Burrows *Statutory Interpretation in New Zealand* (Butterworths, Wellington, 1992) ch 9, especially 125-143.

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of an informed consent provision in what is now Right 6 (2) of the draft Code and the intention of the Commissioner that the Rights be read together. This reinforces the original interpretation of Right 6 (1) as a list of minimum requirements.

Unfortunately the relative clarity of the purpose of this provision was clouded by the addition of the reasonable test in the final Code. The absolute right to information in the draft did not have precisely represented the intention of the Commissioner. This left a gap for legal exploitation which the drafters acted to close.[90] The primary concern turned on Right 6 (1)(b) which required disclosures of options and their associated risks. The Ministry were advised that this could result in situations where the doctor would be obliged to give information about alternative treatments that they did not think would assist the consumer or that the provider knows little about.[91] Examples quoted were "local steroids versus acupuncture versus Chinese herbal medicine".[92] The Commissioner reasoned that clause 3 excuses that provider from giving advice beyond their reasonable area of knowledge.[93] The changes were made anyway.

The standard was lowered from being absolute to being conditional upon objective and subjective consideration of reasonableness. However in doing so they rendered the provision similar to the wording of the doctrine of informed consent as long debated by the courts. Thus it began to look like a more liberal interpretation of the standard for informed consent. This is escalated by its operation in the same context as the doctrine of informed consent.

Prior to the final alterations, breaching Right 6 (1) may not have been synonymous with a breach of the requirements of informed consent. But now the introduction of the reasonableness test must allow for extension of the provision to people in the circumstance of making a decision, and as such render the scope of the information consistent with the necessary disclosure for that situation. Anyone who is exercising a choice is covered by Right 6 (1) by virtue of being a consumer. The fact that they are at a point where a choice needs to be exercised, is squarely within the scope of "that consumers circumstance". Thus the need to make an informed consent, secured by Right 7, is directly relevant to the degree of information provided for in Right 6 (1). The drafters assert that none of the rights are to be considered in isolation and this

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90 Above n 69, 3-4.

91 Above n 78, comments from P Skeggs.

92 Correspondence from H Lockyer to M Luey at the Health and Disability Commissioner's Office concerning the Draft Code of Health and Disability Services Consumers' Right 16 January 1996, Ministry of Health file AD10-23-5#3.

93 Above n 75, 33.

endorses the conclusion that Rights 6 (1) and (2) apply to the same people, and impose the same standard. Right 6 (1) elaborates on the substance of the disclosure, but it still leaves a wide discretion for the fact finder to decide upon. However the listed information should guide Right 6 (2), and both provisions should be used in an integrated way.

E The Contents of Right 6 (1)

Right (2) may embody the standard of care espoused by the Common law in the American and Australian jurisdictions, it may also be the leading provision in strict terms of informed consent, however the impact of Right (1) substantially alters the content of the doctrine of informed consent for the purposes of the Code. Previous case law has consistently stated that informed consent stems from the rights of the patient to self determination. Unfortunately in reality this goal is often relegated to the pursuit of redressing personal injury. Tweski and Cohen wrote in 1988 that:[94]

> The legal system should protect these rights and provide significant recompense for their invasion, rather they continue the singleminded and ill considered attention to personal injury allegedly caused by the lack of information.

A focus on physical injury is a very different thing to the protection of autonomy. This inconsistency in goals is demonstrated in most of the leading cases. Katz suggested in 1977[95] that the Court gives autonomy its separate due and then proceeds with reality of medical, legal and human life. Perhaps this avoidance follows from the practical fact that those who go to the expensive and bother of litigation do so only when the rewards will warrant the effort.[96] The law in relation to damages dictates that these will be cases of personal injury, where the more tragic the consequence the larger the payment. This necessarily affects causation and materiality. When the claim hinges on lack of disclosure, causation will be easier found if the actual risk that eventuated was not disclosed. Commentators argue that this is not the only approach open to the judiciary,[97] however it is the one that has been widely accepted. Subsequently the doctrine of informed consent is often a duty to warn as opposed to a right to be informed.[98]

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94 Above n 42, 609.
95 Above n 1, 139.
96 Above n 42, 616.
97 See part V E.
98 Above n 1, 172.

There is much criticism of the tortious backdrop of negligence law in the medical setting.[99] The Code is the first international initiative to provide for the rights of health consumers in a forum which focuses solely on the entitlements of the individual. The purpose of the Code is to provide for the independence, respect and autonomy of consumers. The purpose of Right 6 is solely to allow for decision making. The focus is not the imposition of liability but the encouragement of fair information. This is assisted by the lack of a causation requirement and the intention of the legislature to provide a system of redress that focuses on restoration of autonomy and acknowledgement of wrongs instead of monetary compensation. As such Right 6 (1) widens the scope of redress well beyond that of the common law. Following is a comparison of the information expected under Right 6 (1) and that which the doctrine of informed consent at common law guarantees.

1 *An explanation of his or her condition and the results of procedures and tests*

(a) An explanation of his or her condition; and...

(f) The results of tests; and...

(g) The results of procedures.

This information is part of the minimum package owed to the consumer. Case law has seldom reached this standard. Shultz illustrates the legal preoccupation with proposed physical touching, that is disclosure of information that precedes a limited range of proposed procedures of an invasive nature. In *Kelton v District of Columbia* [100] the complainant had undergone a caesarean section 6 years earlier and subsequently was unable to conceive. Further surgical investigation revealed that the reason for this was scarring which occurred during the caesarean. The complainant had never been told of this damage. The Court rejected the doctrine of informed consent holding that since there was no proposed "risky operation" the doctrine did not apply. The complainants in *Roark v Allen*[101] were parents of a child delivered by forceps. Although the doctors considered the possibility of skull fracture at the time of birth they dismissed it and never mentioned anything about it to the parents. Only later were the fractures discovered. Again the doctrine of informed consent was rejected. Professional negligence was pursued in *Roark* however this cause of action it entirely ignores the

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99 For example see M Shultz "From Informed Consent to Patient Choice: A New Protected Interest" (1985) 95 Yale LJ 219.

100 413 A.2d 919 (D.C. 1980).

101 633 S W 2d 804 (Tex. 1982).

element of patient autonomy and decides instead in accord with the behaviour of the professional in the eyes of their colleagues.

Extending informed consent to these situations may at first appear inconsistent the informed consent doctrine until the actual position of the complainants is assessed. In both cases the complainants were in a situation where they had a choice to make. If told earlier about her condition and the results of the procedure the woman in *Kelton* could have undergone corrective surgery. At least, armed with the knowledge of her condition she would have had the option not to undergo further investigative surgery. Because this information was held from her she was unaware that she even was in a position of choice. If informed of the possibility of fracture in *Roark* the parents could have got a second opinion and treatment following the birth. As they were unaware of the chance of injury they were deprived of this choice.

The Code would not allow these type of results. It is clear that the consumer must be told of results of tests and procedures, and given an explanation of their condition, or of the child they exercise consent over, to the standard of a reasonable consumer in that consumers circumstance. This conclusion is bolstered by Right 6 (3)(c) which ensures that the consumer can ask for a second opinion. Sufficient information to effect this option must be provided under right 6 (1). Further Right 5 (2) guarantees an environment between the consumer and provider which enables them both to communicate openly, honestly and effectively. Again this points to the communication being such that it provides enough information for the consumer to ask for a second opinion if it is reasonable. The Code is similar to the attitude of the Court in *Gates v Jensen*[102] The complainant's test results suggested possible glaucoma but their doctor decided against responding to it or mentioning it to the them. This was decided on the basis of the doctor's possession of knowledge, and established a new test that any information possessed by the doctor about an abnormality in the patient's body must be disclosed.[103]

2 *Options, risks and side effects and benefits*

> (b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option...

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102 92 Wash. 2d 246, 595 P. 2d 919 (1979) Wash Sup Crt.

103 This was affirmed in *Truman v Thomas* 27 Cal 3d 285, 611 P 2d 902, 165 Cal Rptr 308 (1980). See above n 99.

The information contained in Right 6 (1)(b) can be divided into two categories: information about risks other than the one that eventuated, and information about alternatives to treatment. As a result of a personal injury focus both of these have been undermined in the case law. However the appropriateness of this depends upon the aim that the courts are wishing to pursue. As Weisbard discusses:[104]

> [F]ailure to disclose other risks (or other comparative treatments) which *do not* materialize can skew the patient's comparative assessment of alternative courses of action, thus resulting in an injury that would have been avoided if full disclosure had been made and another alternative pursued. The law's failure to permit recovery on such cases further demonstrates that its primary focus is on the physicians duty to disclose, rather than on any duty to facilitate informed patient choice among alternative courses of action.

(a) Treatment of other risks at common law

Tweski thus argues that whilst personal injury is the focus, single eventuated risks will be the predominant ground for action. This is evidenced as early as *Canterbury* which defined materiality as:[105]

> Optimally for a patient, exposure of a risk would be mandatory whenever the patient would deem it significant to his decision *either singly or in combination with other risks.* (emphasis added)

However it then goes on to require that the undisclosed risk be of the kind of the damage that resulted.[106] Therefore, although material information could include alternatives and risks which may have dissuaded the patient, causation limits liability for non disclosure to risks which eventuated."[F]or otherwise the omission however unpardonable, is legally without consequence". [107]

Even in situations as extreme as failing to disclosure the risk of death, the Courts have held that as that risk did not eventuate the failure was not sufficient to trigger liability.[108]

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104 Weisbard "Informed Consent: The Law's Uneasy Compromise with Ethical Theory" (1986) 65 Neb LR 749,758.

105 Above n 22, 252, and n 30, 787.

106 Above n 30, 791.

107 *Canterbury,* Above n 30, 790.

108 For example *Scarcia v St Paul & Marina Insurance Co* 68 Wis. 2d 1 227 N.W. 2d at 790 and *Ritz v Florida patient's Compensation Fund* 436 So. 2d 987 (Fla. app. 1983).

(b) Treatment of alternatives at common law

Disclosure of alternatives is equally contentious at common law. However are some examples of the availability of options being influential upon the Court.[109] For example in *F v R* the case was lost because, although the doctor failed to warn of the risks of the sterilisation operation failing the Court held that the sterilisation was the only alternative open to the woman and therefore it would not have been refused even if the risk was disclosed. This implies that if there had been a valid alternative with a lower failure rate, the doctor would have been liable for not disclosing it. In the Canadian case of *Haughian v Payne*[110] the doctor failed to advise about the benefits of "conservative management" for a patient with a neck injury. As a result of the operation the patient was injured. The Court held that the failure to discuss the options undermined the patient's ability to provide informed consent. Thus there is some scope for the disclosure of alternatives at common law however this is far less certain and wide reaching than the clear right in the Code.

(c) Risks and alternatives under the Code

The hurdle most dangerous to other risks and alternatives is the causation issue. Often the information is considered material but not sufficient to fulfil the causation element. The Code does not include the causation element. Therefore the question as to whether the non disclosure led to the person undergoing the procedure need not be asked. Instead the requirement of the reasonable consumer in that consumer's circumstance relates only to whether the information was material and the Commissioner is not obliged in this to follow the international legal standard in answering this.

3 Legal, professional, ethical and other relevant standards

(e) Any other information required by legal, professional, ethical, and other relevant standards...

Additional standards can only raise the level of information required by the consumer. As previously discussed other legal standards are less useful than they may appear because of the lack of clarity over which approach to follow. However professional and ethical standards are more influential.

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109 Above n 19, 109.

110 (1987) 55 *SaskR* 99; [1987] 4 *WWR* 97; (1987) 37 DLR 4th 624; (1987) 40 *CCLT* 13, CA.

Professional standards are those imposed internally by which a member of a profession can be sanctioned by their peers. Section 4 categorises health care professionals by the governing Acts that they fall under. Disciplinary bodies follow this pattern.

Ethical standards provided more concern in the drafting of the Code. Ethical standards are included in Right 4 (b) as well as in Right 6. P Skegg made the point that law and ethics are still distinct concepts and that "it does not follow from the fact that something is unethical that there ought to be a law against it".[111] His concern was that the Code was elevating ethical standards into legal ones. In reality this may be an academic difference only, as professional bodies use breaches of ethical standards as grounds for discipline.

Concern was also raised in regard to the reference to "any other standard" which may allow incorporation into law of standards set by groups outside the parliamentary, executive or legal processes.[112] Although this is a valid concern it can be responded to on the basis that standards included under this head will be ones that the health provider have subjected themselves to voluntarily; such as the Organisation Wide Standards of the New Zealand Council on Healthcare Standards. These standards only apply to bodies which have acceded to them. There is an argument that if these bodies are incorporated by Right 6 (1) they become analogous to the panel in *P v Panel on Takeovers and Mergers, ex parte Datafin plc and another*.[113] In this case the body operated a Code which effectively regulated the finance industry in London. Although the source of the bodies power was not statutory, the House of Lords held that the body was judicially reviewable because of the public law nature of their power. Equally influential was the statutory recognition of the operation of the Code and the consequent refusal to legislate in the same area.[114] Similarly, other standards which may become influential under the Health and Disability Code have both a public element and statutory recognition. As such they are drawn into the arena of government via judicial review, thereby negating the original criticism.

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111 Above n 78, 2., see also Correspondence from R Paterson to K Poutasi concerning the Draft Code of Health and Disability Services Consumers' Right, 19 December 1995, Ministry of Health file AD10-23-5#2., 6.

112 Correspondence from B Greer: Nursing Council of New Zealand, to K Poutasi concerning the Draft Code of Health and Disability Services Consumers' Right 11 December 1995, Ministry of Health file AD10-23-5#2.

113 (Norton Opax plc and another intervening) [1987] 1 All ER 564.

114 For a discussion of this case on this point see P P Craig *Administrative Law* (Sweet and Maxwell, London, 1994) 565-570.

Following is a summary of some of the standards on informed consent which may gain legislative standing under Right 6.

(a) Medical Council of New Zealand

In 1990 the Medical Council of New Zealand published a statement on informed consent.[115]

Reflected in this was that the information dissemination should:

a) be in language appropriate to allow that particular patient to make an informed decision.

b) be of such scope as to reflect the knowledge of the actual patient and the practitioner.

c) more generally reflect what a prudent patient in similar circumstances would expect.

Examples of the type of information that the doctor should consider are:[116]

a) The nature, status and purpose of the procedure, including its expected benefits, and an indication as to whether it is orthodox, unorthodox or experimental.

b) The likelihood of the available doctors achieving the specific outcome that the patient seeks.

c) The appropriate and relevant management options or alternatives and their possible effects and outcomes.

d) The associated physical, emotional, mental, social and sexual outcomes that may accompany the proposed management.

e) Significant known risks, including general risks associated with procedures such as anaesthesia, the degree of risk and the likelihood of it occurring for that particular patient.

f) Any likely or common side effects, particularly in drug therapy.

g) The consequences of not accepting the proposed treatment.

h) The name and status of the person who will carry out the management and of others, from time to time who may continue the management.

This is an advanced standard including both subjective and objective elements. Of great importance is the fact that this standard is actually more subjective than the one specified in Right 6. There is scope for a consideration of the particular patient

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115 Above n 12, 59-60. A comprehensive discussion paper was released in 1995, see above n 55.

116 Medical Council of New Zealand *A Statement for the Medical Profession on Information and Consent* (Wellington, 1995).

with the prudent patient being invoked separately to reflect general consideration. The actual patient is not the same as the "reasonable consumer in that consumer's circumstance" unless "reasonable" is interpreted, as argued, as relating to the relationship between the provider and consumer.

If a doctor can be shown to have failed to fulfil this standard, they may be liable for disciplinary action. This is reaffirmed in the *Guide to Doctors Entering Practice* published by the Medical Council.[117]

Although the standard of good medical practice is not synonymous with the legal standard in a patient focused approach it is invaluable as an indicator of the professional assessment of reasonableness. In the jurisdictions where a doctor based standard was applied the concerns of the medical profession featured influentially.

(b) Department of Health

As a result of the Cartwright Report the Minister of Health asked the Department to comment on informed consent for health care providers. This was released in 1991.[118]

The discussion was centred around the principles of autonomy, responsibility and accountability and are intended to assist providers achieve "user centred health care".

The principle of autonomy leads to guidelines that include provision of information that is "accurate, objective, relevant, and culturally appropriate". The minimum standard of disclosure is framed as reflecting the doctors professional assessment. For example "the provider's professional assessment of the nature, likely effects, risks and benefits of the proposed treatment". However in addition to this is added:

> Providers should make sure that the information they give is specific to each individual situation. They should include any information which is likely to significantly affect the user's decision-for instance, the health care provider's own relevant experience.

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117 Medical Council of New Zealand *Extract From: Medical Practice in New Zealand: A Guide to Doctors Entering Practice* (Wellington, 1995) 12-29.

118 Department of Health *Principles and Guidelines for Informed Choice and Consent: For All Health Providers* (Wellington, 1991), all reference in this section are drawn directly from this paper.

> ...As well providers should supply any information that they think may be relevant to the particular user, since users often do not know what questions to ask.

This is all prefaced by the need for effective communication.

Subsequent principles highlight the primacy of responsibility falling upon the provider. Nevertheless the responsibility of the user to provide further information concerning their condition and circumstance is emphasised. This assists the doctor assess what information is relevant.

If these principles were proposed as a legal test of negligent they would be reminiscent of the doctor focus because relevance is judged by the doctors' assessment. Although the information must be relevant, relevance is determined by what the doctor thinks. Arguably this is similar to the "reasonable body of medical men" test.[119] This is mitigated by the requirements of communication and a collaborative relationship, but it may fall short of providing the "right of each person to [their] individual beliefs, desires, values, and goals" as laid out at the beginning of the guidelines.

Notably this is not a guideline that forms the basis for a negligence action. It is aimed at regulating and assisting the medical profession. However it does add to the health culture of informed consent in New Zealand, and as such adds to a picture of the rights of the health services consumer. In relation to the Code it does not advance the rights covered.

(c) Health Enterprise Policies

In 1993 the Ministry of Health also released the Ethical Standards for Crown Health Enterprises: Guidelines.[120] This included a list of suggested policies and procedures which all Crown Health Enterprises (CHEs) should include. In itself this is not binding, however notably a number of Regional Health Authorities (RHAs) had incorporated it into their statements of intent.[121] However all that these guidelines requires is that the CHE has appropriate procedures in place to ensure informed consent is gained.

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119 See above n 15. Also see above Part III C 1 (a).

120 Ministry of Health *Ethical Standards for Crown Health Enterprises: Guidelines* (Wellington, September 1993) see particularly 6.

121 See Central RHA *Statement of Intent 1996-99* s2.1.9, and Southern RHA *Statement of Intent 1996-97* s3.1.9.

The policy of Capital Coast Health is taken from their Clinical Policy & Procedures Manual.[122] Prefacing the policy is a brief reference to the principles of Autonomy, veracity, justice, beneficence, non malificence, respect for person and the Treaty of Waitangi, with emphasis on the relationship of trust between the parties. A part of the Medical Council's statement is quoted followed by:

> The information should reflect what a prudent patient in similar circumstances would expect to receive, and also reflect the knowledge and requirements of the particular patient.

Notably this is the part of the statement which is more subjective that the "reasonable consumer in that consumer's circumstance".

(d) Conclusion

Right 6 (1)(e) introduces a wide range of considerations which extend well beyond the rights directly included in the Code. Given that the Code operates in an area that already interfaces frequently in terms of obligations perhaps this is not a difficulty in practice. For example s 11 (2)(b) of the Health and Disability Services Act 1993 obliges providers to uphold ethical requirements. Both the Southern and Central RHAs demand consistency with the Ministry of Health guidelines on Informed Consent, the guidelines for CHEs and the Code. Professional bodies apply these standards as part of the grounds for discipline. The Code now forms part of this matrix of obligations. However in doing so it is important to recognise that the parameters of the Commissioners mandate extends beyond the express rights in the Code.

F Right 6 (3), Specific Queries and that Particular Patient

A duty upon a doctor to answer a query with a full and frank reply is well established in the common law. Even the *Sidaway* approach covers specific questions, subject to therapeutic privilege.[123] In *Smith v Auckland Area Health Board* the Court held that although they were not laying down a general standard for disclosure, any questions asked about risks must be afforded a "careful and reasonably accurate reply".[124] This was to reflect the reliance the patient placed upon the answer. *F v R* and *Rogers* make

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122 Capital Coast Health *Clinical Policy & Procedures Manual: Informed Consent Policy* (Wellington, 1995).

123 Above n 17, 895, 898, 902-903.

124 Above n 14, 227-228.

reference to the patient's desire for the information.[125] However scope is maintained for therapeutic privilege,[126] with the Judge in *Rogers* stating:[127]

> [T]he fact that the patient asked questions revealing their concern about the risk would make the doctor aware that this patient did in fact attach significance to the risk. Subject to the therapeutic privilege, the question would therefore require a truthful answer.

Battersby v Tottman[128] is an Australian case where this privilege was applied. The doctor failed to disclose the risk of serious eye damage from a prescribed course of drugs, to a patient suffering from mental illness. This was done because although the treatment was considered necessary to save her life, her mental illness would prevent her from making a rational decision. The Court upheld this suppression on the grounds that the patient was likely to react irrationally to the information and make a poor decision or even exhibit "hysterical blindness".

Thus if the disclosure may actively harm the patient either mentally or physically, or if the disclosure will disturb the patient so extremely as to preclude rational decision making, the use of therapeutic privilege may be justified. There is some danger of this avenue being used to "devour the disclosure rule itself".[129] Therapeutic privilege must not be used to replace the patient's assessment with the doctor's just because the two are inconsistent.

Therapeutic privilege is maintained in the Code under Clause 3 (3) as a defence of the consumer's clinical circumstance. However when this is read along with the right to respect, dignity and independence then there is little scope for a wide interpretation.

G The Right Not to Receive Information

The New Zealand Medical Association (NZMA)[130] and a number of the submissions queried the omission of a clear right to waive disclosure. This right is expressed in the World Health Organisation on the Promotion of Patient's Rights in Europe 1994, and was quoted in the draft Code submitted for public consultation.[131] It was not included.

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125 Above n 28, 192-3.
126 For a discussion of therapeutic privilege see Kennedy above n 33, 211-215.
127 Above n 36, 50.
128 (1985) 37 SASR 524.
129 Above n 30, 789.
130 "Providing Patient Information, or Pushing It?" *NZMA Newspaper,* No 142, 26 January 1996.
131 Above n 58, 34.

This is a right that exists at common law, which is mentioned in prominent cases, but seldom applied directly.[132] It is a manifestation of the very principle upon which the right to information stems, the right to autonomy. Forcing information upon someone is as much a violation of their autonomy as withholding information they require.

Kennedy asserts that if required to decide the issue, the Courts would probably uphold the waiver of information on risks and alternatives so long as it was real and voluntary, but require disclosure of the nature and purpose of the procedure.[133]

The NZMA posited that the "ludicrous" situation could arise where the patient does not want the information but the doctor must provide it.[134] This is incorrect. The existence of a right is not the same as the existence of an obligation. The consumer can exercise their right to be fully informed, it provides them with a legal claim on the information. It does not oblige them to take it. This is enforced by Right 1 (b) which places a duty on providers to enable the consumer to exercise their rights, the actual exercise of the rights is within the jurisdiction of the consumer. By specifying the reasonable consumer as the consumer in that consumers circumstance, the Commissioner allows the individual needs of the patient to dictate what information they require. By prescribing the right to be "fully informed" as opposed to be in possession of full information, the Commissioner allows this to be tested by the needs of the individual.[135] If the provider possesses the knowledge that the consumer does not wish to be fully informed, it would seem a mockery of the rights to respect, independence and dignity that they can ignore it and proceed with disclosure. It will be the role of the consumer to convey their request.

H The Lack of Causation

1 Causation not an appropriate element of a breach

Given that the Code does not define the elements of informed consent there is scope for the Commissioner to look to the common law to assist her. This is strengthened by the obvious awareness of the Commissioner in the drafting of the Code of these legal standards. The Commissioner will need to be wary of direct application of these

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132 See discussion in Giesen above n 36, par 827-31, *Reibl* and *F v R*.
133 Above n 33, 233.
134 Above n 130.
135 Above n 58, 34.

standards as they contain some elements that are not appropriate to the HDCA and the Code.

Primarily this involves the scope for imposition of a causation element. It is this element which has been most destructive to patient rights in the use of the informed consent doctrine.[136] Despite the fact that injury is not relevant to a breach of Right 6, there is danger that if the Commissioner turns to the usual legal debates in the case law, some element of causation will be transposed. In this debate causation impacts on both the final causation element and the determination of material information in terms of the duty of care. This is discussed earlier in this paper.[137] The writer argues that causation, under either element, is inappropriate when establishing a breach of the Code because it violates the intention of the scheme. The Code is not a protection from damage or an instrument of regulation or blame. It is primarily a tool of the individual to guarantee that their rights are being observed. The rights that they are granted by the Code are rights to services and procedures, with disclosure of information being a procedure, and not to results. Thus it is consistent that the sanctions should hinge upon the delivery of those procedures and not upon whether the breach had an adverse result.

2 *Causation not an appropriate element of damages*

If causation has any relevance this may only be at the damages stage before the CRT, following a conclusion that a breach has occurred. The scope of this relevance is arguable. The writer argue that the usual test for causation is not introduced to the Code by way of the damages provision.

Section 57 governs the award of damages. The primary ingredient is a breach of the Code. Quantification is then based upon:

> (a) Pecuniary loss suffered as a result of, and expenses reasonably incurred by the aggrieved person for the purpose of, the transaction or activity out of which the breach arose:
> (b) Loss of any benefit, whether or not of a monetary kind, which the aggrieved person might reasonably have expected to obtain but for the breach:
> (c) Humiliation, loss of dignity, and injury to the feelings of the aggrieved person:
> (d) Any action of the defendant that was in flagrant disregard of the rights of the aggrieved person.

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136 See above part III C 3 (b).
137 See above part III C 3 (b).

The Tribunal is free to determine whether the breach resulted in the loss as they see fit. This need not be in accordance with the objective test of causation demonstrated in the majority of cases.

It is important to note that at law the imposition of damages is separate from the determination of damage. Modern law has tended to consider determination of damage or causation as an element of the breach. Thus causation is not considered as part and parcel of the imposition of damages.[138] Therefore the common law position on causation is not directly relevant to s 57. Issues of remoteness are dealt with under causation not under damages.[139]

Applying usual tortious standards, s 57 determines how best the claimant can be placed back in the position they would have been but for the breach. This is limited by reasonableness of the claim. Reasonableness relates more consistently to a standard upon the claimant not to demand unreasonable measures to return them to the position they consider they would have been in. This distinguishes it from reasonableness as used in the sense of the mythical reasonable patient. In support of this, the test of reasonableness is attached only to the additional expenses incurred and not the general pecuniary losses such as loss of earnings. All general pecuniary losses are compensatable whether they are the result of the actions of a reasonable consumer or not. Conversely, the fact that the complainant is used to treatment in a private hospital with a wine licence even though they could be treated as quickly and well under public health will not oblige the defendant to compensate the private medical expenses. Additionally reasonableness is attached to anticipation of benefits. Intangible quantification such as this require a limitation when someone is being rendered liable for them. Loss of a chance is only compensatable if the chance was substantial and not speculative.[140] Missing the week of work where your colleagues decided to purchase a lotto ticket that happened to win is not a loss that the defendant should or would reasonably be liable for.

Therefore if a doctor does not disclose information which although a reasonable patient would not have acted upon, the particular patient would have, the doctor is liable for all the loss of earnings and expenses, except those which are unreasonable to place the person in the position they would have been in or misrepresent the position they would have been in.

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138 Above n 29, 862.
139 *The Wagon Mound (No. 2)* Dias [1967] C.L.J. 62.
140 *Davies v Taylor* [1974] A.C. 207 (H.L.). See discussion in Todd, above n 29, 298.

I Conclusion

Because the Code exists separate to the common law it can reinterpret some of the conventional assumptions which have operated to disadvantage the subjective needs of health services consumers. This is most notable with regard to the reasonable consumer. This is consistent with a context which concentrates on the rights of the consumer to procedures of informed consent and not upon compensating injuries.

Additionally, in specifying the types of information that the reasonable consumer would expect in Right 6 (1) the Code returns the boundaries of material information to information required to allow informed consent, as opposed to information sufficient to warn the consumer and protect the provider.

VI THE EFFECT OF RIGHT SIX ON NEGLIGENCE AT COMMON LAW

A Negligence and Statute Law

Although the common law and statutory law are conceptually different concepts there are still interfaces between them. A transfer of ideas between the forums is becoming more acceptable.[141] This reflects a desire to retain consistency, and to acknowledge that statutes in areas analogous to the common law may represent the current perception of public policy. This approach has been favoured in New Zealand, [142]when Cooke P was influenced by the Misuse of Drugs Amendment Act 1978 as an indication of legislative policy in determining on an issue of client-solicitor privilege. As Lord Diplock said in 1979:[143]

> Where over a period of years there can be discerned a steady trend in legislation which reflect the views of successive parliaments as to what the public interest demands in a particular field of law, development of the common law in that part of the same field that has been left ought to proceed upon a parallel rather than a divergent course.

In *Matthews v MacLaren*[144] this approach was applied specifically in the area of negligence when a pleasure boat operator was found responsible for a negligent rescue attempt which resulted in two deaths. The Court was influenced by statutory

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141 See discussion above in Burrows, n 89, 259-263.
142 *R v Uljee* [1982] 1 NZLR 561.
143 *Erven Warnink BV v J Townend & Sons (Hull) Ltd* [1979] AC 731, 743.
144 (1969) 4 DLR (3d) 557.

provisions which imposed a responsibility to rescue strangers at sea. Although this did not apply the Court stated; "the common law must keep pace with the demands and expectations of a civilised community"[145] and thus must not be less solicitous than the statutory provision.

This is similar to the line that has been taken concerning the criminal law and negligence. However a crime may be regarded as setting a minimal standard, lower than the duty of care in a negligence action, thus a criminal acquittal will not necessarily prove that the tortious duty of care was fulfilled.[146]

The Code is a clear example of a decisive legislative policy. The wide consultation requirements which contributed towards its formulation add credence to the claim that it represents the public perception of appropriate behaviour between providers and consumers. However this will only be indicative of the standard of care, in the end the conclusion will be a result of all the circumstances of the case, and the degree of influence will depend on how closely the analogy can be drawn between the provision of the Code and the negligence claimed.

B Conclusion

There is no direct link between the standard of negligence regarding informed consent and Rights 6 of the Code. This will be especially relevant for ACC which requires negligence of cover. The purpose of ACC is to compensate for personal injury independent of an assessment of fault.[147] Ostensibly this is even more consumer focused than the Code which needs to attach liability to a provider and as such needs to balance fairness between them. The consumer focus provides a clear parallel between the two schemes. The additional element of no fault in ACC should push it even further towards subjective consideration of the claimant. There is no excuse for following the English approach which focuses upon the doctor more than the patient.

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145 Above n 144, 563.

146 See discussion in Todd above n 29, 277-279.

147 See the Long title of the ARCIA and A O Woodhouse *New Zealand Royal Commission to Inquiry into and Report Upon Workers' Compensation.* (Government Print, Wellington, 1967).

VII BREACH OF A STATUTORY DUTY

A Scope For a Statutory Duty

Another important interface between the Code and the common law is the potential liability for a breach of statutory duty for those who breach the Code. This is considered in this paper for two reasons. First it determines the breadth of influence that the Code has in the common law. Second if the Code sustains an actionable statutory duty the link between the interpretation of Right 6 and the traditional approaches of the common law are more closely linked than may initially appear.

1 Existence of a duty

Section 20 of the HDCA and reg 1 (2) of the Code, make it clear that a duty exists. Following each principle included in the Code is the requirement of a corresponding duty and obligation on the health care provider.

2 Constructing a statutory duty

The imposition of a duty under a statute does not necessarily disclose a right upon on the individual to seek damages. This requires an inference that parliament intended a civil right of action. Such an inference is made in light of all the circumstances and a construction of the Act.[148] Presumptions are applied in determining this intention, however case law evidences that these are often applied inconsistently. Some guidance can be taken from Lord Diplock's statement in 1982:[149]

> ...[O]ne starts with the presumption...that 'where an Act creates an obligation, and enforces the performance in a specified manner... that performance can not be enforced in any other manner'...[T]here are two classes of exception to this general rule. The first is where on the true construction of the Act it is apparent that the obligation or prohibition was imposed for the benefit or protection of a particular class of individuals...

These presumptions are examined below.

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148 *Atkinson v Newcastle* (1877) 2 Ex. D 441, *Cutler v Wandsworth* [1949] AC 398, 407.

149 *Lonrho Ltd v Shell Petroleum* (No. 2) [1982] A.C. 173, quoted in Stanton below n 150, 35.

(a) Alternative Modes of Enforcement

If a statute has no enforcement provisions it is more likely that a statutory duty will be found.[150]

> [W]here an Act creates an obligation and enforces the performance in a specified manner, we take it to be a general rule that performance cannot be enforced in any other manner.

However this is not conclusive.

One of the main purposes of the HDCA and the Code is to create effective remedies for a breach. Such provisions indicate legislative intention to limit the pursuit of remedies in other spheres. In describing the Bill, both the Rt. Hon J Shipley and K O'Reagan reiterated that this is an Act aimed at resolving disputes at the level closest the source where possible.[151] The preamble of the Act states that it is to "secure the fair, simple, speedy, and efficient resolution of complaints of the rights encapsulated by the Code".

Indeed the comprehensive harmonisation of the various remedies available at present to redress medical breaches of rights affirms this. Interfaces between remedies under ACC are considered in section 52 (2). Interfaces between the Commissioner and medical disciplinary bodies was carefully considered and are linked to the Medical Practitioners Act 1995 which came into force on the same day as the Code. The Commissioner acts as a place of first inquiry for such complaints and reserves a function for itself in bringing and advocating along side the complainants.[152]

Read together, these demonstrate an intention to avoid court procedures which are often the antithesis of the aims under this Act. For example, litigation is adversarial not mediated, expensive not financially accessible, protracted not "speedy". It is exactly the related difficulties of litigation that this procedure was created to avoid. It is unlikely that parliament intended to create another means of enforcing the Code.

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150 *Doe dem. Murray, Lord Bishop of Rochester v Bridges* (1831) B & Ad. 847. See also *Auckland CC v Hellaby* [1924] NZLR 964, *Wyatt v Hillington London Borough Council* (1978) 76 LGR 727. and discussion in K M Stanton *Breach of Statutory Duty in Tort* (Sweet & Maxwell, London, 1986), 34.

151 (1994) 543 NZPD 3735 and 4298.

152 See "Medical Practitioners Act 1995: Discipline" *MC News*, May 1996.

(b) The Class Test

Provision of a mode of enforcement has proved indeterminate in situations where a benefit was intended for a discernible class as opposed to the general public. Classes have included gas consumers[153] and the homeless[154], therefore there is fair expectation that health consumers would fulfil the definition. The members of this class are presumed to be able to sue for a breach.

However a further examination of cases where this has been used when alternative remedies exist, reveals that the remedies provided were not of the type the HDCA prescribes. In *Southwark London Borough Council v Williams*[155] where the availability of judicial review because of a possibility of ministerial intervention was considered inadequate to negate a statutory duty. This was because judicial review was considered unsatisfactory for the use of an individual with regard to obligations owed personally to them. The Court indicated that judicial review is a remedy more appropriate for public law resource allocation than for the individual whose statutory right to accommodation was being breached.[156] The New Zealand Court of Appeal in *Pease & Others v Eltham Borough Council* [157] held that a general remedy under the Crimes Act, s 129 did not preclude a statutory duty as it did not demonstrate an intention on parliament to exclude others remedies nor did it detract from individual rights of the members of that class. *MacEachern v Pukehohe Borough Council*[158] involved the provision and maintenance of fire hydrants, no specific penalty was provided for the breach of this. However a general catch all penalty existed for breaches not otherwise covered. The Court held this was insufficient to exclude a statutory duty.

In all these cases the remedy available was not the most appropriate for redress for the individual claimant. As such the court inferred that the legislature would not intend to remove a remedy which was best suited to the needs of the claimant.

These circumstances are different from the HDCA. As noted the purpose of this Act is to provide the most appropriate response to the individual rights of the

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153 *Morton v Eltham Borough* [1961] NZLR 1 and *Pease & Others v Eltham Borough Council* [1962] NZLR 437.

154 *Southwark London Borough Council v Williams* [1971] Ch. 734.

155 Above n 154.

156 See Stanton above n 150, 38-39.

157 [1962] NZLR 437

158 [1965] NZLR 330.

claimant. Thus the writer concludes that the class exception would not aid an application for a statutory duty and redress for its breach.

B Nature of the Action

1 Negligence tort or separate action

If the Code could maintain a statutory duty, the nature of this duty is fundamental. This alters whether the common law doctrine of informed consent is directly connected to Right 6. If the statutory duty is not a negligence action there is no direct link between the Code and negligence.

The United States and Canada support statutory duty as a particular species of negligence. This is favoured because often the statute will crystallise the reasonable care test, and provides certainty where the common law can not. If accepted, there is further issue with the evidentiary value of the statute in defining the standard of care for negligence. Either the statute defines negligence per se or it is merely prima facie evidence of negligence. The later has been supported in the Canada.[159]

In the UK statutory duty is viewed as distinct from negligence.[160] Therefore, a finding of breach of statutory duty will not conclude the issue of the standard of reasonableness for negligence. If the common law test is higher or broader this will not be limited by the statute.[161] Interplay will remain as statutory provision may alter the accepted practices.

C Conclusion

If a statutory duty could be constructed, unless the breach of statutory duty is regarded as an action in tort the distance between the Code and the Common law remains.

However it a stronger argument that no statutory duty lies within the Code. The HDCA is intended to avoid the very court procedures that a statutory duty would allow.

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159 *Saskatchewan* (1983) 143 DLR (3d) 9.
160 *LPTB* v *Upson* [1949] AC 155.
161 *Bux v Slough* [1973] 1 WLR 1359.

VIII CONCLUSION

The doctrine of informed consent is an acknowledgement of the primacy of the patient as an individual person in the medical setting. Its interpretation through tortious negligence, has often operated to undermine this intention. Instead it has focused on determining liability in a manner that the medical professions find easiest to operate within, predict and avoid. Thus what was a duty to inform patients sufficiently to facilitate informed decision making, became a means of avoiding responsibility for risks which eventuated following a failure to warn. The difference between the fairy tale and the reality is vast.

It this environment that the Code was born into. However the Code has not become part of this. Instead it exists separately with its own standards and its own enforcement. The ethos of the HDCA is markedly different from that of negligence actions. The Code does not determine breaches according to physical injury, focusing instead on procedures. This is an acknowledgement that health is broader than physical well being. This acknowledgement is not that far from the original intention of informed consent, that the patient decides what is in their own best interests, using whatever personal values that they choose. By focusing on processes, the integrity of informed consent can be recaptured and released from the compromises of causation.

Similar to the North American and Australian approaches the Code refers to the reasonable consumer in that consumer's circumstance. In this paper the writer has argued that this can be interpreted to require the consumer to act reasonably to those involved, instead of requiring that they decide reasonably according others. This is consistent with the purely subjective right to refuse medical treatment in the Bill of Rights, and avoids unfair expectations on inadequately informed health professions. However even interpreting "reasonable" in the traditional manner the Code takes the patient's rights further than the doctrine of informed consent has previously.

Case law has focused on the direct steps which resulted in damage. Under the Code the consumer is given rights to the full range of information required to make choice and give consent. This includes an explanation of their condition, and the results of tests and procedures. Importantly it also requires information about the options available to the patient and the risks and advantages of each option. This is not restricted to covering the risks of the procedure chosen but allows for the consumer to choose between procedures, having a full picture of their options not just the likelihood of risks of the recommended treatments.

This paper contains a warning for Code interpretation. In examining the case law it will not be sufficient just to ignore the obvious causation discussions. Causation is introduced more subtly into the discussions about the duty of care via the materiality element. causation is not appropriate in the HDCA culture.

Finally it is concluded that the Code may have an impact beyond its own parameters. Although not an action of negligence, a Court considering such an action would be correct to consider the Code as a legislative and societal indication of current perceptions about the requirements upon the medical professions. It must be conceded that the purpose of the Code and neglience are not identical. However it must also be realised that the purpose of informed consent is the same whatever the enforcement setting.

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body.[162]

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162 Above n 25.

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