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CONSENT TO MEDICAL AND SURGICAL PROCEDURES

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(I) CONSENT TO MEDICAL AND SURGICAL PROCEDURES

CONSENT:

Problems involving aspects of consent to medical and surgical procedures have become prominent in the field of medical-legal cases. A physician may not lay hands on a patient without the patient's consent (express or implied.) The bases of relief in the medical and surgical cases are two:

(a) negligence and

(b) assault and battery.

Thus a doctor who administers treatment or performs an operation upon a patient without the latter's consent or consent of someone able to give consent on patient's behalf, subject to certain exceptions, may become civilly liable either in an action for assault and battery or negligence. Also he may become criminally liable for assault and battery. The distinction Courts make between the two causes of action is that assault and battery is based on an intentional act, while negligence is based upon an unintentional act. These two causes of action are jointly present in many cases. Thus a plaintiff may jointly have a cause of action for assault and battery as well as for negligence resulting from the same operation and may sue on either ground.

Any person suing a physician for assault and battery as opposed to negligent conduct need only show that treatment was given without authorisation and need not show any real damage. But in order to make out a case in negligence patient must show that he suffered actual damage as a result of the doctor's conduct. When a patient sues in battery he is entitled to nominal damages even though he cannot show any real damage. But when a patient has suffered actual damage or injury by reason of an unauthorised operation, he will be able to recover substantial damages even though the surgeon can show (a) that he performed the operation in good faith,

(b) and that it was performed in the best interest of the patient,

(c) and that the operation or treatment was carefully and skilfully carried out.

Following cases will illustrate this point. In the Canadian case of Mulloy v Hop Sang (1935 1 WWR 714) the plaintiff

surgeon who had, on an examination of the plaintiff under anaesthetic, decided that an immediate operation was necessary to prevent blood poisoning, amputated the hand of the defendant which was badly injured due to an accident. The plaintiff, in these circumstances sued for the professional fees and the defendant denying he was liable counter claimed for damages for assault. Even though the Judge found that the operation was necessary and was performed in a highly satisfactory manner the Court awarded damages for trespass to person in respect of the unauthorized amputation which the patient expressly prohibited.

In the American case of Hively v Higgs (1927 253 P 263) surgeon who operated on the septum of the patient's nose, removed her tonsils without her consent. The Court awarded substantial damages rejecting the argument that tonsils had no known useful purpose. Thus it is clear that it is no defence to an action in assault and battery that the unauthorized operation was performed with due skill and care and that it was performed in the best interests of the patient.

There have been no decided cases in New Zealand Courts on consent in medical suits. This paper sets out to demonstrate the problems which may arise in this connection and to suggest possible solutions, and reference will be made to American, Canadian and English cases to show how other legal systems have attempted to solve these medico-legal problems.

(II) WHEN IS CONSENT UNNECESSARY?

However there is one instance where consent is generally regarded as unnecessary, i.e. in cases of emergency or crisis situations. These emergency cases usually arise in two ways --

i) where a person has been rendered unconscious in an accident and a doctor is confronted with conditions which require immediate treatment in order to safeguard the life, limb and health of the patient and,

ii) where a doctor is authorized by the patient to perform one course of treatment during which he discovers an unanticipated emergency condition, unrelated to the first condition, which requires

immediate attention.

It is a well established rule in Canada and America that a doctor is justified in performing an operation or administering treatment without obtaining a patient's prior consent, where circumstances demand that action be taken before it is possible to obtain consent. It is unlikely that this principle will not be recognized in this country if the point were to come up for decision before Courts. Following cases will illustrate the rules followed by Canadian and American Courts with regard to such emergencies. In the American case of Mohr v William (1905 104 N.W. 12) a doctor engaged to perform an operation upon one of the plaintiff's ears, after anaesthetizing her and examining her ear found that the condition was not as serious as he supposed. However, he found a very serious condition in the other ear and proceeded to operate thereon. She was dissatisfied with the surgical result and brought an action for assault even though the operation was in every way successful and skilfully performed. The Court giving judgement for the plaintiff held that no danger to her life or health existed to bring the matter under the emergency doctrine and the operation was an infringement of the right of inviolability of person.

In Franklyn v Peabody (228 N.W. 681) the plaintiff suffered from a stiff finger as a result of an injury. Her surgeon advised an operation to which she consented. When the finger was cut surgeon found an adhesion between the tendons and decision was made that best results could be obtained by enclosing the tendons in fascia. An incision in the plaintiff's thigh was made for the purpose of obtaining fascia lata with which he proceeded to sheath the tendon. Plaintiff who suffered from a muscle hernia as a result of this treatment brought an action for assault against the defendant. On appeal, it was held that no emergency existed sufficient to justify dispensing with plaintiff's consent.

In the Canadian case of Murray v McMurchy (1949 2 D.L.R. 412) a surgeon performing a caesarean operation tied off the patient's fallopian tubes in order to preclude a second pregnancy, when he found tumours which he felt might be dangerous in the event of such pregnancy. The Surgeon was held liable for assault,

The Court holding that there was no emergency immediately threatening the life or health of the patient pointed out that the fact that tumours might constitute a hazard in the event of future pregnancy was not a sufficient justification for taking such a drastic step without consent. But in Wheeler v Barker (92 Cal. app. 2d 776) a surgeon operating for a tumour found, upon opening the plaintiff's abdomen a large tumour and that he felt it was necessary to and did perform a subtotal hysterectomy removing the plaintiff's uterus, It was held that the defendant was justified. The Court said that consent need not have been obtained from the patient because the growth had increased from a small size to that of a lemon and unless checked at that point it would have greatly increased in size and would have been a threat to patient's life.

In the Canadian case of Marshall v Curry (1933 3 D.L.R. 260) a doctor engaged to perform a hernia operation was held to have been justified in removing the plaintiff's testicle, where in the course of the operation he found conditions which indicated that removal was required both to repair the hernia and to protect the patient's life.

Thus the rule accepted in Canadian and American cases with regard to emergencies is as follows: -

> Where the danger disclosed is of such a nature that immediate steps are necessary in order to preserve the life, limb or health of the patient, a doctor is justified in taking such steps even though no consent has been obtained. On the other hand, if the condition disclosed is not of such a nature as to involve any immediate danger to life, limb or health of the patient then the doctor may become liable in assault for performing an operation to which the patient has not consented.

<u>What is the juridical basis upon which it is possible to excuse a surgeon from liability who operates upon his patient without his consent</u>.

In the American cases a number of different suggestions have been put forward. Some of the cases tend to speak in terms of implied consent in these situations. But this is an obvious fiction. Implied consent in its real sense is consent implied from conduct for e.g. holding one's arm out to be vaccinated implies consent to the vaccination.

The phrase 'good surgery' has been used in some of the cases but its use is not helpful, it is general, vague and ambiguous.

A case of importance is Bennan v Parsonnet (1912 83 N.J. L.20) where a new principle of law was propounded, namely that of holding the operating surgeon to be the representative of the patient to give consent. However this has been criticized by Chisholm J in Marshall v Curry -

> "There is unreality about that view. The idea of appointing such a representative, the necessity for it, the existence of a condition calling for a different operation are entirely absent from the minds of both patient and surgeon. The will of the patient is not exercised on the point. There is in reality no such appointment."

I think the most satisfactory treatment of the point comes from Chisholm C.J. in the above-mentioned Canadian case of Marshall v Curry (1933 3 D.L.R. 260).

> "In these emergency cases it is not useful to strain the law by establishing consent by fictions-by basing consent on things that do not exist. Is it not better to decide boldly that apart from any consent the conditions discovered make it imperative on the part of the surgeon to operate, and if he performs the duty skilfully and with due prudence, that no action shall lie against him for doing so?"

What is the position with regard to a patient who expressly prohibits treatment even in emergencies creating an imminent threat to a patient's life or health?

In the American case of Rolater v Strain (137 Pac. 96 (1913)) the patient presented herself for treatment of an inflammatory condition of her toe. She was advised to have it incised and drained after removing any foreign material that might be present. She agreed to the treatment but told the doctor not to remove any bones. During surgery he found that access to the area of infection was blocked by a sesamoid bone and only way to drain the area was to remove the bone. Though the doctor testified that serious consequences could have followed if it was inadequately drained, the Court held him liable, stating that it was relying on Mohr v. Williams.

However, it can be pointed out that as the physician had permission to treat the toe, being restricted in how he would treat it, the case differs from Mohr where the doctor went outside the scope of his original consent to treat an ear which he had no permission to treat.

In the Canadian case of Mulloy v Hop Sang (1935 1 WWR 714) the doctor was held liable for the unauthorised amputation of a hand which the patient had expressly forbidden to amputate despite the fact that it was badly damaged, that three surgeons agreed, that the amputation was necessary in order to prevent blood poisoning. It is clear from these cases that if the patient expressly forbade the surgeon to exceed the consent, he will be liable in battery if he disobeys instructions. However, the English Courts have taken a different approach. In the only English case on the subject Beatty v. Cullingworth (1896 B.M.J. 1546) patient instructed the surgeon not to remove both ovaries though she consented to a single operation, but the surgeon found both ovaries diseased and removed them. It was held that he was legally justified.

But the proper rule should be that a doctor should be justified in disregarding his patient's express instruction where a condition exists or arises which constitutes a threat to patient's life. On the other hand, if the condition that exists is not of such a nature as to involve a threat to patient's life, limb or health, then the doctor should not proceed to disregard such express prohibition.

What is the position with regard to an adult patient who refuses to consent to life-saving medical treatment such as a blood transfusion?

This is an area where the individual's right to determine what shall be done with his own body and the law's traditional view of sanctity of life come into direct conflict. Should a Court order that treatment be given or should it respect the individual's commands and let him die? The few American Courts which have faced this problem are divided as to the proper course.

In the case of Application of President of Georgetown College Inc. (1331 F 2d 1000; 377 U.S. 978 (1964)) a mother of a 7 month old baby had massive internal bleeding due to a ruptured ulcer and this necessitated an immediate blood transfusion. Hospital officials sought a Court Order

authorizing the transfusion. The judge ordered a transfusion on the ground that it was necessary to preserve the status quo. He thought that the State had an interest in preserving the life of a mother of a seven month old child, sufficient to justify authorising transfusions to save her life.

Another case of interest is Raleigh Fitkin-Paul Morgan Memorial Hospital v Anderson (42 N J 421; 201 A2d 537 (1964)). In this case the patient, a Jehovah's Witness, in her 32nd week of pregnancy suffered from a condition that would necessitate blood transfusions during the delivery of her child. When the physicians came to know about the patient's objection to the proposed treatment they sought judicial authorisation. On appeal, the Court held "the blood transfusions (including transfusions made necessary by delivery) may be administered if necessary to save her life or the life of her child, as the physician in charge at the time may determine." at 423. By this, if the Court meant only that the mother's life should be saved if such was required to save the life of her child, then the case can be regarded only as a logical extension of the power of State as parens patriae to authorise medical treatment on children over their parents' objections. On the other hand, if the Court meant to authorize transfusions on the mother even though it was not necessary to save the child (i.e. after the child was delivered) then this cases is clearer than the Georgetown case in holding that an adult patient cannot reject life-saving treatment. However writers have expressed the view that there is some ambiguity as to the true meaning of the decision.

In another American case Erickson v Dilgard (252 NYS 2d 705 (S.C. 1962)) where an adult Jehovah's Witness patient (without complicating factors such as unborn or minor children) refused an emergency blood transfusion, Court held that he had the right to refuse a blood transfusion and in refusing an emergency transfusion, was simply making a medical decision which the Courts could not refuse.

However, it appears that answers given by Courts vary according to the facts and circumstances of each case but on the whole support the view that an adult has the right to use what therapy he will accept even if refusal means death, unless there are unusual circumstances such as an unborn child or dependant children.

However, a recent American case (Re Estate of Brooks 32 Ill 2d 361) held that where the refusal of treatment was due to religious conviction, such action constituted an infringement of religious liberty. However, the issue is unsettled in the United States. Therefore the question whether the rendition of emergency life-saving medical treatment on the person of the objecting adult is proper, remains to be answered.

Euthanasia and Life Saving Treatment.

Under the present law euthanasia would constitute homicide, the patient's consent being no defence. The primary reason why the law condemns 'mercy killing' is the interest the society has in the life of the individual. 'The public interest in the life of the individual is attested by the fact that euthanasia continues to be illegal homicide and by the remnants of the common laws severe penalties for suicide, e.g. the rules against abetting and in some places against attempting suicide.(1) If this is the reason why the individual has no right to consent to his own death in the euthanasia situation then it could be said that such a patient would have no right to prohibit life-saving medical treatment.

Suicide and Life Saving Treatment.

At this point it could be pointed out that it is obviously proper for a physician to save his patient's life by unauthorised treatment, if the physician in doing so is in the same position as the individual who has prevented suicide. The policy of the society must be against allowing its members to commit suicide even though it is no longer a crime. Therefore to hold a physician who gives unauthorised treatment to save the life of the patient liable and the rescuer from suicide privileged would be absurd. Take for example two hospital patients both in need of blood transfusions, one rejects them because of a desire to die, the other because of religious reasons. Is it justified if the law allows a patient wishing to live but preferring death to breach of religious faith to die, while forcing the one wishing to die, to live? If the non-religious suicide should be prevented, then so should the religious suicide.

In these analagous areas of euthanasia and suicide the law has uniformly denied significance to the individual's consent to his own death and consequently it should be expected

that the same result will follow in the case of refusal of lifesaving treatment. In the American case of Meyer v Supreme Lodge K.P. ((1904) 70 NE 111) the New York Court of Appeal held that a physician who gave medical treatment to an attempted suicide contrary to his express wishes was not liable in trespass.

The Council of the Medical Defence Union (in England) in its booklet called 'Consent to Operative Treatment' containing suggested formulae for various contingencies, sets out a special form to be signed by a patient who refuses to have a blood transfusion even though this may be necessary "to render the operation successful or to prevent injury to my health or even to preserve my life."

However, the procedure recommended might not give the surgeon full protection. A surgeon who undertakes to perform an operation on a Jehovah's Witness knowing that the necessity for a blood transfusion may arise and that he will then be precluded from giving it, might be sued by the patient or his relatives for negligence. Also it is recommended by the Union that "if the patient's signature cannot be obtained a note to that effect should be entered in the medical records" and the "patient should be informed by the surgeon that in the circumstances he cannot accept complete responsibility." However, it has been pointed out by Diana M. Kloss [2] 'if the patient refuses to sign the prescribed form it cannot be said that he has consented to any operative procedure whether involving a blood transfusion or not. No surgeon can absolve himself from legal liability by mere unilateral declaration. However if the patient subsequently to refusing to sign the form, voluntarily and freely submits to the operation, it is probable that the Court would hold that he has in fact assumed the risk of necessity for a blood transfusion arising even though there is no written evidence to that effect.'

Since the issue is not judicially resolved in practice a surgeon will always hesitate before performing an operation on Jehovah's Witness, which would involve a transfusion without any good evidence that the patient assumed the risk and freely absolves him from liability.

(III) SURGICAL OPERATIONS AND THE QUESTION OF BODILY HARM:

Surgical operations by their very nature, although thought to be beneficial to the patient, involve injury or physical harm to the patient at least in the short run. But surgical operations for medical purposes are obviously lawful, although they involve infliction of wounds on the patient - (Stephen. Digest Art. 310). Thus when a surgeon performs a doubtful operation (i.e. where the legality of the operation is in doubt), his criminal liability may become an issue. In New Zealand, determination of criminal responsibility of a surgeon who performs such an operation rests exclusively on statute, i.e. on the provisions of the Crimes Act 1961. It would seem that the surgical steps involved in doubtful operations such as sterilisation, sex conversion, grafting of organs (i.e. live donor transplants) etc., may come within the definition of the expression 'to injure' in S.2 (1) of the Crimes Act as meaning 'to cause actual bodily harm'. Although the terms 'actual bodily harm' have not been specifically defined in the Crimes Act, they have been defined in a number of English cases. This term is used in the Crimes Act as distinct from grievous bodily harm. See S. 188 (1) and 188 (2).

All that is necessary to constitute actual bodily harm (according to Archibold 32nd ed. P. 959) is that there should be hurt or injury calculated to interfere with health or comfort of the prosecutor. It need not be an injury of a permanent character nor need it amount to what would be considered to be a grievous bodily harm. "It may mean internal as well as external injuries and need not be permanent nor dangerous nor amount to maiming, disfigurement or disablement." (Russel P. 627) In R v Donovan (1934 2 KB 498 at 509) it has been defined as follows: "Bodily harm includes any hurt or injury calculated to interfere with the health or comfort of the prosecutor. Such hurt or injury need not be permanent, but must no doubt be more than merely transient and trifling." In Regina v Miller (1954 2 Q.B. 282 at 292) Lynskey J. held that this included a hysterical and nervous condition resulting from an assault, taking the view that an injury to man's mind is actual bodily harm. "Bodily harm" according to the House of Lords in Director of Public Prosecutor v Smith (1961 A.C. 290 at P.332) "needs no explanation. 'Grievous' means no more and no less than really serious." The House of Lords said that there was no warrant for giving the words a meaning other than that which they convey in their ordinary and natural meaning.

The relevance of this aspect of criminal law is that it provides a basis for saying that many surgical operations are prima facie unlawful. Without further justification not only would operations be criminal acts, but they would also be unlawful in the civil law and surgeons might be liable to pay compensation for the consequences of their acts, even though they had exercised all reasonable care. Therefore it is relevant to consider the criteria that convert unlawful acts into lawful surgical operations. Consent is one of these. Other criteria are contained in S.61 of the Crimes Act.

(IV.) CONSENT AS A DEFENCE:

When a doctor performs an operation that is said to be a prima facie assault, the question arises how far is the consent of the person assaulted a defence to a charge?

Consent of the patient or victim is no defence to a charge of crime. Assault is a crime as well as a civil wrong. If the victim avails himself of his civil rights only and sues for compensation consent is a good defence. But if he or police prosecute for a crime consent is no answer; the individuals consent is irrelevant.(3)

Examination of the cases, dealing with consent as a defence, will reveal that there are limits to the degree of physical harm to which a person can effectively consent; but where the line is to be drawn is by no means clear. In some of the English cases, the defence of consent has been treated as follows:

1) Consent is ineffective to exclude liability in respect of assaults which are of a dangerous or serious nature; i.e. when there is a likelihood of bodily harm.
R.V. Coney (1882 Q.B.D. 534 at 547) It is submitted that this criterion has very little value as a general principle; clearly at least one type of 'aggression' upon the body can be lawful, even when it is extremely dangerous. viz. a medical operation.

2) Consent is no defence, when the conduct consented to has the tendency to create a 'breach of the peace'. Thus in R.V. Coney (1882 Q.B.D. 534 at 539) Cave J. said:

"The true view is, I think, that a blow struck in anger or which is likely or intended to cause bodily harm is

not an assault and that assault being a breach of the peace and unlawful, the consent of the person struck is immaterial. If this view is correct a blow struck in a price fight is clearly an assault, but playing with single sticks or wrestling do not involve an assault, nor does boxing with gloves in the ordinary way and not with the ferocity and severe punishment to the boxers deposed to in R.V. Orton."

If blows struck in boxing are lawful, then it is clear that it is permissible to submit to the infliction of some degree of bodily harm.

3) Consent is a defence when the conduct in itself is not unlawful. R. v Donovan (1934 2 K.B. 498) In this case a man was charged with beating a girl for purpose of sexual gratification. The Court of Appeal took occasion to go into the general question whether the consent of the prosecutrix would constitute a defence in law. The view taken by the Court was that "if the blows struck were likely or intended to do bodily harm to the prosecutrix" then they would be unlawful acts and her consent would be no defence. "For this purpose we think that bodily harm has its ordinary meaning and includes any hurt or injury calculated to interfere with the health or comfort of the victim. Such hurt or injury need not be permanent but must no doubt be more than merely transient or trifling." (At P. 509). However the Court said "there are well established exceptions to the general rule that an act likely or intended to cause bodily harm is an unlawful act," e.g. sport or play, manly diversions and reasonable chastisement of a child.

Lord Devlin[4] thinks if the rule is right the question in future will be whether a particular case does or does not constitute 'a well recognised exception'. He also pointed out that most surgical operations would come within this exception except those operations performed in circumstances which were thought to be injurious to the public; for example, sterilisation operations without good medical reason and abortion. Thus it is clear that consent is a defence to criminal liability in the case of certain assaults including many forms of surgical operations. However when the particular assault is in itself unlawful or where it is prohibited by law (such as abortion) the consent of the person assaulted affords no defence.

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The seriousness of the bodily harm likely to be incurred is then a very important factor in determining whether consent is legally operative. But it is clearly not the only factor involved. Account must also be taken of the purpose of the operation, for example if the purpose of the operation is against public policy, then the operation becomes unlawful.

Here it becomes relevant to consider separately surgical procedures such as abortion, sterilisation, sex conversion, grafting of organs etc. and the possible effect in such cases of the doctrine laid down in R v Donovan as to the validity of consent in respect of an assault which interferes with health or comfort. Also it is important to consider the special defence available under S.61 of the Crimes Act 1961 in relation to each of these categories of operations.

(V.) ABORTION:

The most obvious example of an unlawful operation is that of abortion and in New Zealand it depends upon statute. Apart from cases where abortion is possible under Crimes Act of 1961, abortions are statutory criminal offences whether performed by doctors or unqualified persons. S.182 (2) is the ground on which therapeutic abortion can be performed and is considered to be the legislative enactment of the principle enunciated in R v Bourne where McNaughten J. held that intention to preserve the life of the mother rendered an abortion lawful and extended the concept of life to include both physical and mental health. Under S. 183 unlawful use of an instrument or the administration of a drug on a woman with intent to procure miscarriage is an offence. A defence based on the lawfulness of that use would still have to be concerned with the physical and mental health of the mother. Therefore all abortions performed by a doctor other than for the purpose of preserving the life of the mother (extended to include both physical and mental health) are unlawful. Thus it is clear that a doctor in New Zealand cannot escape the penalty for performing an illegal abortion by arguing that the woman consented, i.e. consent is no defence to a charge of illegal abortion.

It must be added that the fundamental grounds of justification of abortion in the New Zealand law are good faith and preservation of the life of the mother (under S.182 (2)) and not consent so that the expulsion of a foetus under those

circumstances can be lawful and even where the woman did not consent. Should lawfulness of abortion ever be extended to other grounds such as economic or eugenic grounds, the factor of consent will of course, be introduced. (see G. Williams Sanctity of Life P.214).

What is the effect of consent by a woman to an illegal abortion on the civil liability of a doctor?

In other words can a woman who has willingly undergone an illegal abortion, later sue the doctor who performed it in battery and recover damages?

With regard to this question legal opinion is divided. The view that no action lies is supported by Salmond.(5) The contrary view is put forward by Windfield.(6) In America, there is a sharp conflict of authority on the question whether consent of a woman to an illegal abortion precludes recovery of damages for the consequences of that act. Thus in Hunter v White (1923 31 A.L.R. 980) it was held that a woman, who voluntarily submitted to an abortion and sustained injury thereby caused by the negligent treatment afforded her by the defendant physician who performed the operation, could not maintain an action for recovery of damages since the transaction was not merely immoral but was illegal as being in contravention of a statute. So too, in Martin v Morris (21 A.L.R. 2d 370) an action by a woman to recover for injuries sustained by reason of an abortion was dismissed, the Court reasoning that it would not lend its support to an action based upon an immoral and illegal transaction. In Miller v. Bennet ((1949), 21 A.L.R. 2d 364) the Court denied recovery in an action brought by personal representative of a married woman who submitted to an abortion, on the ground that the decedent was guilty of a moral crime and had been the participant in the violation of an anti-abortion statute. Thus in these cases where recovery is denied, the reasoning of the Courts is based upon the premise that the female was a willing participant in the crime of abortion and having taken part in an illegal transaction, is barred from maintaining an action arising out of such transaction.

However, in Miller v Heddesheimer ((1924) 33 A.L.R. 53) the administrator of a woman who died as a result of an abortion

was permitted to recover from the physician who performed the operation, the Court holding that the consent of the person injured will not preclude recovery, when such act involves a violation of the public peace, or the life of the person involved. In Martin v Hardesty ((1928) 21 A.L.R. 372) it was held the the consent of the woman to the operation could not be interposed as a defence to an action brought to recover damages for the death of a woman as a result of an illegal abortion, and in support of its position stated the rule that consent of a person to an act prohibited by law is not a defence to an action brought for injuries to the consenting party resulting from such act. Again in Hancock v Hullet (1918, 21 A.L.R. 2d 372) the father of a minor upon whom an abortion was performed was held not to be precluded by reason of daughter's consent to the operation, since as a minor she could not legally consent to a transaction which constituted a criminal offence. Thus in these cases in which it has been held that recovery could be had, by the woman or her representative notwithstanding her consent, the grounds for recovery have been predicated upon various lines of reasoning. However, I think the better view is that there should be no remedy in damages, to those who claim for the results of a crime in which they willingly participated.

When an abortion is negligently performed there have been instances where the Courts have awarded damages in negligence despite the consent of the woman. In Andrews v Coutler (1931, 21 A.L.R. 2d 373) a woman who was abandoned after an illegal abortion by a doctor, even though she was seriously ill as a result of the abortion was held able to recover damages, notwithstanding her consent. The Court further held that recovery would be permitted where complaint was not based merely upon an allegation that the physician was negligent but alleged also that after the deceased suffered complications resulting from the operation he failed to give her any treatment whatsoever, and completely abandoned her without informing her family of her condition.

Third parties who have suffered damages as a result of an unlawful abortion will not be prevented from claiming damages unless they claim directly through a willing participant in the crime. In Touriel v Benveniste (reported in 1961 110 U. of Penn L.R. 908) a husband brought an action against the surgeon

who had performed an illegal abortion on the plaintiff's wife; thus depriving him of his unborn child. The Court held that he had a prima facie cause of action, which was not barred by his wife's consent to an illegal operation, since he was claiming in his own right for the invasion of his marital interest in the unborn child. With regard to the question, whether the husband could sue for loss of his wife's services as a result of an illegal operation to which she has consented, it is submitted that as long as he in no way participated in the criminal operation, he should be able to recover despite his wife's consent.

(VI.) STERILISATION:

Sterilisation is a medical operation performable either on a male or female whereby the ability to procreate is eliminated. But it does not preclude further sexual intercourse from a physiological standpoint and does not as is sometimes erroneously thought, de-sex the individual.(7) In the man the most common surgical method of sterilisation is called vasectomy, accomplished by cutting and tying the vas deferense above the testis. In the woman the operation is normally performed by cutting and tying the fallopian tubes between ovaries and the womb or by removing the womb. (hysterectomy.)

Before we go on to the question whether a person can validly consent to such an operation and if so what effect it has on a physician's liability, it is necessary to consider whether such an operation is lawful. The law with regard to sterilisation operations is uncertain. Countries have approached this problem in different ways and consideration of some of the approaches would be instructive.

American Approach:

Several American States specifically provide that voluntary sterilisation undertaken for therapeutic reasons is legal. In three American States voluntary sterilisation is expressly prohibited by statute except for therapeutic or eugenic purposes. In a number of States there is no legislation whatsoever concerning the legality of voluntary sterilisation. Following are a few American cases which have dealt with the question of legality of such operations. In the case of Christiansen v Thornby (192 Minn 123:255) a husband brought an

action for the recovery of damages for anxiety and expenses he experienced in connection with the wife's pregnancy and successful delivery, subsequent to his having undergone a vasectomy to ensure sterility and avoid the danger of the wife's bearing a second child. On the question of legality, the Court held that under the facts of the case, a healthy child having been born to the couple without complications, the voluntary sterilisation was justified on therapeutic grounds due to wife's unlikely prospects for a normal delivery. The Court held under such circumstances neither the contract for the operation nor the operation itself was against public policy and illegal on that basis.

In the case of Shaheen v Knight (11 Pa. Dist 2 Co. R 2d 41 1957) the husband sued the physician for failure to sterilise him permanently basing his right to recover on breach of contract. However, this case is distinguishable from Christiansen in that no medical necessity existed for the operation but only the plaintiff's desire for permanent sterility to avoid birth of future children. The Court while stating that a contract to accomplish contraceptive sterilisation was not void as against public policy held that public policy forbade the recovery of damages for birth of a healthy child as a result of that contract being breached.

In another American case Custodio v Bauer (251 Cal App. 2d 303 1967) husband and wife brought an action against the physician for the negligent performance of a sterilisation operation and for breach of contract to sterile. With regard to the question of legality Court stated "it is generally recognised that a sterilisation operation for therapeutic purposes to protect the physical or mental health of the patient or in the case of vasectomy, the wife of the patient, is not against public policy ..... It has been suggested that such an operation for purpose of family limitation motivated solely by personal or socio-economic considerations is likewise not anti-ethical to public policy ..... Where not prohibited by statute the matter would appear to be one of individual conscience ....." The result of these cases appear to be that in America the prevailing view is that a voluntary sterilisation, if carried out with necessary care and consent, is not contrary to public policy.

British Approach:

The problem of legality of the operation has not been raised in England except in the obiter dictum of Denning L.J. in Bravery v Bravery (1954 3 AER 59 C.A.) In this case wife brought a divorce action on grounds of cruelty alleging that her husband had voluntarily undergone an operation for sterilisation, after birth of their 1st child, without her consent and thus caused her health to suffer. Two of the judges ruled that this was not cruelty while the third Justice Denning ruled that it was cruelty and that sterilisation for a motive of this kind was unlawful. He made the following observations in the dissenting judgement, with regard to the question whether such an operation is contrary to public policy and common decency so as to make consent no defence to its criminal characterisation. At P.P. 67-8 "..... A Sterilisation Operation. When it is done with a man's consent for a just cause it is quite lawful, as for instance, when it is done to prevent the transmission of a hereditary disease; but when it is done without just cause or excuse it is unlawful even though the man consents to it. Take a case where a sterilisation operation is done so as to enable a man to have the pleasure of sexual intercourse without shouldering the responsibilities attaching to it." The operation is then plainly injurious to the public interest.

Denning L.J. went on to cite the case of R v Donovan to support his proposition that a vasectomy operation performed on a married man (with his consent) was a criminal assault which public policy would not allow consent to excuse. The other 2 judges disagreed with him. However in this case majority opinion would support the view that a vasectomy operation performed on a man with his consent is not illegal.

The degree of harm or injury involved is not the decisive criterion but is rather only a major element in determining whether or not the operation is not contrary to public policy. Surgical operations by their very nature, although thought to be beneficial to the patient involve injury or physical harm at least in the short run. As a result, the criminality of a surgical procedure should not simply be judged by the degree of injury caused but rather by its effect on the individual concerned, as a

responsible member of the society and on the members of the public. It is a social policy decision. Consent is a relevant factor in the making of the decision, but the question of necessity in an immediate and broader context, is perhaps the consideration that should be determinative.(8)

In a medical-surgical context, consent and medical necessity ordinarily operate as defences to the initial characterisation of the operation as an assault, presuming the object of or the motivation for the sterilisation is lawful.(9)

Question arises what then is a lawful purpose?

In 1960 Medical Defence Union in England sought the opinion of legal counsel upon whether the sterilization of a male or female was legal and if so in what circumstances. The opinion expressed was published in the Annual Report of the Medical Defence Union(10) 1961 as follows: 'Sterilization is not unlawful whether it is performed on therapeutic or eugenic grounds or for other reasons, provided there is full and valid consent to the operation by the patient concerned.'

Lord Devlin in a 1960 address(11) to doctors seems to have accepted the opinion of the English Medical Defence Union, that non-therapeutic voluntary sterilisation is lawful, if proper consent is given, and the operation is performed for a purpose 'not otherwise criminal'. He also stated "I would suggest as a broad principle that an assault should not be treated as criminal if it is done -

(a) for the purpose of averting danger to life or grave and immediate injury to health or

(b) with the consent of the other party and for a purpose which is not otherwise criminal.

Abortion for example is a mere crime in itself and so consent to it would remain irrelevant; the act would have to be justified under the first heading. If it is thought that sterilisation although done by consent, should be prohibited except for grave medical reasons, then it should be made a crime in itself and should not try to catch it as a form of assault."

In 1966(12) the Secretary of the English Medical Defence Union re-affirmed the opinion expressed by counsel in 1961, i.e. that sterilisation carried out merely on grounds of personal

convenience, (In other words as a convenient method of birth control) is a legitimate and legal undertaking, but reminded the profession that this opinion was not based on any stable judicial authority as it had never been tested in Courts.

Even though the law of England regarding sterilisation remains to be stated authoritatively and Bravery v Bravery clarified, it is unlikely that a surgeon would be held liable for a criminal assault for performing a non-therapeutic sterilisation operation if it is performed with the consent of both husband and wife.

It (13) is unlikely that Courts would today create new crimes of this kind so that unless and until they are made illegal by statute, operations for sterilisation and castration will be treated in the same way as other surgical operations.

It is (14) submitted that this broad public policy question should not be answered by Courts in any given case but that the question should be answered by statute. In the meantime consent should nullify any criminal liability for the performance of a voluntary sterilisation. In (15) the absence of some compelling legal justification as evidenced in a statute on this subject, it is the desirable course to maximise personal freedom. Assuming that sterilisation of a spouse can be justified on certain grounds, an important question still remains.

Should both spouses consent or is consent of the party submitting to the operation sufficient?

If a surgeon operates to sterilise a married person on non-therapeutic grounds without the consent of the other spouse, he may well lay himself open to a civil action for damages. The 1966 Annual REport of the English Medical Defence Union indicated, such a course might constitute a loss of consortium to the unconsenting spouse.

Apart from loss of consortium action, unilateral submission to a sterilisation operation in Britain would afford the unconsenting spouse grounds for divorce by reason of cruelty.(16)

The better view seems to be that, as a general rule, consent of both parties should be obtained. However, there may be special circumstances justifying sterilisation of a consenting spouse even in the absence of the other spouse's consent. The example given by Williams 'The Sanctity of Life' P.101, the mother of a large family who will suffer a nervous breakdown should she become pregnant again will fall within thiscategory of case.

If it is accepted that the consent of both spouses is necessary, it follows that the sterilised spouse (having consented) will have no claim for damages, while the other spouse, having not consented, will in fact have such a right of action. If a sterilisation operation is performed upon a spouse who has been misled into believing that an operation is an entirely different one and the intact spouse has consented to the sterilisation, the former will be able to sue, whereas the latter will lose his or her right of action.(17)

POSITION IN NEW ZEALAND

Civil liability of a surgeon who performs a sterilisation operation.

Provided the patient and the spouse of full age, who have full knowledge of all the consequences of the operation consent to the surgery there is no reason why a sterilisation operation performed without negligence should be an offence under the civil law. The (18) forms of consent which surgeons in New Zealand require their female patients and their spouses to sign before a sterilisation operation are as follows --

'I hereby agree to undergo the operation of sterilisation. I fully understand that this will produce permanent inability to become pregnant.

Signed .....
Witness .....
Date .....'

'I here by agree for my wife to undergo the operation of sterilisation. I fully understand that this will produce permanent inability to become pregnant.

Signed .....
Witness .....
Date .....'

PRACTICE IN NEW ZEALAND

D. Urquhart[19] Urologist, Wellington Hospital states 'the usual person referred for vasectomy is a married male in his thirties or forties, with 2-3 children; whose wife has found the 'pill' unsuitable for various reasons ..... the couple are usually adamant that they have enough children and that further children would be disastrous for socio-economic reasons. They have usually discussed the problem fully between themselves and with their practitioner ..... It is important to interview both husband and wife together so that one can assess the couple and see that they fully understand the nature of their request ..... It is essential to emphasize that it takes 2 - 3 months before the male is rendered sterile. I have both husband and wife sign a statement which I witness confirming that they fully understand the nature and effect of the operation and that they give me their consent to have it carried out on the husband. Consent on the part of the patient is a necessary legal safeguard in any operation to protect the surgeon, the wife's signature in this is to protect the husband from divorce suit on grounds of constructive desertion.' He further states 'It is my practice, then to carry out a vasectomy for any couple, who for socio-economic reasons wish to limit their family or who for contraceptive convenience wish to have it done. They must be a stable happily married couple, generally with a family who are prepared to discuss their problem fully with me and give me their written permission to operate and assurance that they understand the nature of their request.'

'I would not limit the operation to married males but I would be very cautious in operating on single males unless the reasons were ethically acceptable. One must probe carefully for a history of neurosis or psychosis as subsequent ailment may easily be attributed to the vasectomy itself. If there is doubt as to the suitability or otherwise of the case a second medical opinion should always be sought.'

Consent and the Criminal Liability of a Surgeon who performs such an operation in New Zealand.

There is no statutory reference in New Zealand regarding sterilisation compulsory or voluntary. Criminal liability of a surgeon who performs such an operation depends upon the provisions of the Crimes Act of 1961. Here the question arises whether a

sterilisation operation can be said to constitute a 'grievous bodily harm' or a 'maim' within the terms of S.188 (1) or S.188 (2) of the Crimes Act of 1961. S.188 (1) and (2) have extended criminal liability for assault to include maiming, disfiguring or causing grievous bodily harm to any person either with intent to cause grievous bodily harm or with intent to injure. If the word 'maim' is given its normal meaning 'to mutilate, cripple, to deprive of the use of' it is not unreasonable to consider sterilisation operation as a 'maim'.

The next question is whether a surgeon, who performs such an operation in New Zealand can bring himself within the defence available under S.61 of the Crimes Act.

Where a sterilisation operation is performed on any male or female where contraception has proved impracticable or unreliable, resulting in the birth of unwanted children and if the physician is able to show that the patients physical or mental health is liable to suffer or deteriorate from the birth of future off-spring such operation should be considered as legal within S.61 of the Crimes Act as it is carried out for the benefit of the patient, provided other conditions required thereunder are satisfied.

If the surgical steps involved in a sterilisation operation can be said to constitute a 'maim' within the terms of the Act, then the consent of the person assaulted is not a defence at least to criminal liability in the absence of other conditions required under S.61.

(VII.) CÓNSENT AND S.61 OF THE CRIMES ACT:

A more difficult question is the relevance or the effect of consent on the criminal liability of a surgeon who seeks protection under S.61 of the Crimes Act. In New Zealand the relevance or the effect of consent on a surgeon's criminal liability who performs such an operation would depend on the interpretation that would be given to S.61 of the Crimes Act.

There is no case law on the defence of S.61. However Adams[20] in 'Criminal Law and Practice in New Zealand' (page 129 1964 ed.) states - ....."the fact that section protects only from criminal responsibility suggests that it was

not framed with a view to operations performed with consent or at any rate not solely with reference thereto ..... The section indeed seems to be superogatory in regard to such operations. This does not exclude its application to them and it may be taken for granted that the section will apply to operations performed with consent. But, in terms, the section is equally applicable to operations performed without consent or in spite of the refusal of consent and on its face might be read as justifying, from the criminal point of view, the forcible subjection of an unwilling patient to an operation which the surgeon rightly or wrongly deem to be for his benefit. This result can be avoided only by construing 'reasonable' not as referring merely to therapeutic reasonableness or reasonableness from the point of view of the patient's physical state and circumstances, but as including the matter of his willingness or unwillingness to undergo the operation. The wider view would probably be taken even though the patient's refusal were itself unreasonable.

If the word 'reasonable' in the section is interpreted to mean not only therapeutic reasonableness or reasonableness from the point of view of the patient's physical state and circumstances but also to include a patient's willingness or unwillingness to undergo an operation, then it could be said that the consent of the patient would be a relevant factor in determining the question of reasonableness under S.61.

(VIII.) SEX CHANGE OPERATIONS:

There is evidence that in various parts of the world sex change operations have been performed and as a result of such surgery persons who were born with genitalia of a man or of a woman have been able to have those replaced by the genitalia of a woman or of a man respectively. However it must be noted that this physical conversion surgery is an irreversible yet incomplete therapy.

One impediment for a homosexual seeking surgery is the fear of medical community that the operation is of dubious legality. Doctors are equally afraid of possible civil liability for battery. Professor Glanville William states[21] 'Even the so-called change of sex operations have not been thought of as raising legal problems, although, it involves surgical interference with the genital organs. Since surgical operations have been characterized by the Common Law as p.f. assaults, one hesitates to accept

his conclusion with regard to sex-change operations which usually involve drastic methods of surgery.

Effect of consent on the civil and criminal liability of a surgeon who performs such an operation:

Consent and the Civil Liability:

Professor G.P. Barton states (22) 'So long as the patient is able to form a reasoned judgement on the question and consents to the operation, then he or she will have no action in law against the surgeon in respect of any cutting, engrafting or otherwise changing his or her genitalia.' The only remedy against the surgeon will be in negligence where in the performance of the operation the surgeon has failed to diagnose, advise, operate or otherwise treat the patient with the degree of skill and care appropriate to the circumstances.' Therefore it is sufficiently clear if negligence were not alleged in a civil action for assault against the performing surgeon, consent may be taken as a complete defence; (i.e. volenti non-fit injuria) provided it is given with the full knowledge of the patient.

In England the form of consent which surgeons require their male patients to sign before an operation for sex re-assignment is as follows --

'I ..... of ..... do consent to undergo the removal of the male genital organs and fashioning of an artificial vagina as explained to me by .....(surgeon). I understand that I will not alter my male sex and that it is being done to prevent deterioration in my mental health.

.....(signature of patient)' (23)

Consent and the Criminal Liability of a Surgeon:

Consent is a defence to criminal liability in the case of certain assaults such as sexual intercourse, blows struck in pursuance of lawful sports, and most surgical operations or medical treatment. (R v Donovan 1934 2KB 498). But if the particular assault is in itself unlawful e.g. illegal operations like abortion or sterilisation without good medical reason, the consent of the person is not a defence at least to criminal liability. Therefore it becomes relevant to consider whether sex-conversion operations are unlawful.

The most recent judicial pronouncement and apparently only case dealing directly with the legality of a consented to

conversion surgery comes from Argentina.[24] The case involved a charge of criminal assault brought against a doctor for performing corrective surgery on a male homosexual, whom the Court felt did not manifest feminine characteristics. On appeal, the higher Court held the consent of the patient was no defence to the criminality of a surgical assault regardless of his impaired mental state. Such surgery could not be consented to lawfully. The higher Court stated on the defence of consent - 'The consent of the victim is not a defence. The act constitutes grievous bodily injury and in view of the consequences, a society cannot accept the consent of the victim whose interests are protected by this Court .....'

Criminal law of most countries today appears flexible enough to handle this problem without amendment.[25] In Canada[26] although there are no cases in point, it has been suggested that re-assignment surgery would be legal under S.45 of the Canadian Criminal Code, which is similar to S.61 of the Crimes Act of N.Z. provided it could be shown that the trans-sexual was in severe mental distress and would benefit from surgery. In N.Z. there is no specific legal authority dealing with conversion surgery as a therapeutic measure as is true in most countries but it has been suggested by Professor Barton [27] that sex-conversion operation may come within the definition of the expression 'to injure' in S.2 (1) of the Crimes Act as meaning 'to cause actual bodily harm'. S.188 (1) of the Crimes Act states that it is an offence for anyone, with intent to cause grievous bodily harm, to wound, maim, disfigure or cause grievous bodily harm to any person, S.188 (2) makes it an offence for anyone to do the same act with intent to injure (as distinct from intent to cause grievous bodily harm.) Professor Barton thinks that if sex-conversion operation does not amount to grievous bodily harm it could be considered to amount to a 'maiming', when the term maiming is given its normal meaning 'to mutilate, cripple or deprive the use of'.

Now the question to be considered here is the extent to which an individual's consent will insulate the performing surgeon from criminal liability for the surgical invasion. Professor Barton[28] in his article states if such question arises, it is likely to arise in the context of a criminal trial before a jury and therefore it may never receive a rationally articulated answer.

Before concluding that a surgeon who performs such an operation in N.Z. incurs criminal liability and that consent of the patient is immaterial, it is desirable to consider whether a performing surgeon could avail himself of the defence stated in S.61. A surgeon who seeks protection under this section would have to prove -

(a) that the operation is for the benefit of the patient and

(b) that it is reasonable having regard to the patient's state at the time and all the circumstances of the case.

Removal of genital organs would hardly be considered to be for the benefit of the patient unless it could be justified on grounds of mental well-being of the patient. Thus if a surgeon who performs such an operation is able to show that mental and psychological pressures on the trans-sexual is so great as to put himself on the verge of self mutilation or suicide he could bring himself within S. 61 (as the operation being carried out for the benefit of the patient) provided it is reasonable. If the word 'reasonable' is given a wide interpretation so as to include patients willingness or unwillingness to undergo the operation, it is probable that consent of the patient would be taken into account by the Court in considering the reasonableness of such operation.

The question may eventually be resolved by saying that consent to such operations will only negate their criminality when such operations can be said to be reasonable and when their purpose is considered to be for the benefit of the patient.

(IX.) ORGAN TRANSPLANTATION:

The problem of consent by the donee is the conventional one of whether the donee has consented to the surgical procedure and the fact that procedure involves a transplant does not essentially change the nature of the judicial approach to questions of consent, assault and battery or negligence. Any serious problems of consent involved in the transplantation are apt to concern the consent of the donor only.

The problem of consent from the point of view of the physician is that when he fails to obtain the necessary consent he may expose himself to a criminal or civil action. A defence sometimes available to the physician is that of emergency

(discussed above), where circumstances were such as to justify the procedure undertaken even in the absence of the normally required consent of the patient (i.e. when there is a serious threat to life or health of his patient.) But it is clear that a defence of emergency would not be available in the transplantation area at least where an action is brought by the donor.

Two fundamental questions have arisen with regard to consent by transplant donors -

(a) what is the necessary capacity for a proper consent (capacity to give consent in general will be discussed in detail later,) and

(b) what is the permissible extent of consent in this area.

Extent of Consent:

In this connection it has been suggested that a distinction must be drawn between consent for tissue removal that will not, and that which will or might be harmful to the living donor.(29) The South African Union Post Mortem Act treats the removal of 'tissue replaceable by natural processes of repair' from living donors differently from the removal of naturally irreplaceable tissue. Under the Act, former class of tissue may be freely removed while it allows the removal of latter only where the donor consents in writing and 2 other physicians certify in writing that the removal will not prejudice that person in any way.(30)

The removal of naturally irreplaceable or repairable tissue such as blood transfusions and skin grafts does not create much problems where proper consent is obtained.(31) The legal effect of consent by a living donor to the removal of tissue not naturally replaceable remains uncertain.

Can a living donor validly consent to the removal of one of his organs for the purpose of transplantation?

At the(32) same time as the law will not allow consent to justify homicide, it is consistent that it will not allow the removal from living donors of unpaired vital organs such as the liver, lungs and the heart. S.63 of the Crimes Act of 1961 clearly provides that no person can consent to being killed.

To quote Lord Killbrandon[33] 'the law at the moment considers that the procedure which the surgeon adopts is so severe that it is incapable of being consented to by the person being operated on, unless that operation is for the persons own benefit. If that is not the law at the moment many people think it is .....'

The[34] high chances of satisfactory existence of one kidney probably explains why legal liability has not sought to be imposed for removal of one of paired organs. Even if loss of one kidney involves a slightly increased risk to the donor, most have felt that it is clearly outweighed by the need of the prospective recipient.[35]

Question whether a surgeon in N.Z. who removes an organ from a live donor guilty of a crime? is to be considered next.

Bodily harm has been defined in R v Donovan (1934 R.B. 498, 509) as follows: 'Bodily harm includes any hurt or injury calculated to interfere with the health or comfort of the prosecutor; such hurt or injury need not be permanent but must no doubt be more than merely transient or trifling.'

Practice of taking blood from donors for purpose of blood transfusions is not capable of being legally challenged except on religious grounds. But it must be noted that position of a blood donor and kidney donor is clearly different in degree and it is difficult to categorise blood transfusion procedure as anything more than the infliction of bodily harm of a trifling or transient nature whereas removal of a kidney is most certainly the infliction of harm which is capable of being more than transient or trifling.

Thus a surgeon in New Zealand who removes an organ from a living donor could be held criminally liable under 188 (1) or 188 (2) of the Crimes Act which deals with causing grievous bodily harm, even though the donor has freely and knowingly consented to the procedure. It is hard to imagine that defence under S.61 would be available to a surgeon in the transplantation area at least in an action brought by the donor because of the lack of benefit to the donor.

Important question with regard to live donor transplants is not the extent of consent but rather the capacity for consent. While a minor as donee of an organ presents the same legal problems as she does in conventional surgical situations (which will be discussed later) as a prospective donor he presents more complex problems with regard to the potential liability of the surgeon.

At common law minors were incapable of giving consent to surgical procedures for the benefit of another. Bonner v Moran (126 F 2d 121 D.C. Cir. 1951). When the parents consent to a transplant from a minor donor, is the surgeon protected thereby from liability? Is the lack of benefit to the donor child enough to with-hold protection that results from parental consent to surgical procedures on their minor children under normal circumstances?

Three cases from Massachusetts(36) appear to shed some light on this difficult question. These cases involved kidney transplants from 2 sets of identical twins aged 14 and one set of 19 year old twins. In all three cases children as well as their parents or guardians consented. Before proceeding with the kidney removal the hospital Trustees in each case sought declaratory judgements from Courts. Courts basing their opinion on expert medical and psychiatric evidence held that surgeons could proceed with the operations on the consent of parents and that of both twins without incurring civil or criminal liability finding that the operation was necessary for the continued good health and future well-being of the donor twin, for if the operation was not performed and the sick twin were to die this would result in a 'grave emotional impact' on the potential donor.

Court's reliance on the 'benefit' to the donor, diminishes the precedential value of these cases for future situations in which no such close relationship between donor and donee exists or when donor because of extreme youth and mental incompetence cannot appreciate the significance of his donative act.

With regard to donors who are closely related to the recipient, question frequently asked is whether consent is purely informed and voluntary. When donor and donee are closely related, there will be much social and psychological pressure on those who know that their failure to be a donor will result in

the death of the sick person. It is doubtful whether there can ever be informed voluntary consent in situations like this.

Possible solutions to the problem of consent with regard to transplants.

My submission is that, if live donor transplants are going to be of importance in future, legislation is in fact the best solution.

Meyers,[37] in his book 'The Human Body and the Law' suggests that adults of full capacity, who have been expressly advised of all risks involved in the operation, by a physician not a member of the transplant team, should be allowed to consent to donate tissue; but only when the benefit to be derived by recipient of such tissue clearly outweighs the detriment agreed to be suffered by the donor. It is clear that such limitation would not allow a person to consent to the removal of a vital organ resulting in donor's death. But it would not prevent a person from consenting to the removal of a kidney, when risk involved in the donation is in fair proportion to the benefit that is likely to be conferred upon the donee by the transplant. He also suggests that difficult borderline cases could be referred to Courts for declaratory judgements. It is submitted that this type of legislation is desirable rather than legislation prohibiting consent by an individual to medical treatment not for his benefit but for the benefit of another. He also suggests that under such legislative formulation children and incompetent persons should be excluded and that removal of only naturally replaceable tissue (such as blood or skin) from a child should be made possible and even then only when the child is of an age to understand the nature of his consent, when his parents or guardians also have consented and when the donations had been authorised by a 2nd physician no way involved in the procedure.

(X.) COSMETIC OPERATIONS:

Consent[38] to undergo a completely useless operation undertaken by a surgeon who knows its uselessness - something which in the medical world is not without precedent is doubtless contra bonos mores, whether the operation is performed for purposes of gain or any other purpose, irrespective of the degree of skill with which this operation is performed. Consent to a cosmetic operation, it is submitted cannot be considered offensive to good morals unless the operation constitutes a threat to the patient's life or health.

If a [39] person wereto undergo a surgical operation in order to improve his facial appearance in some rather trivial respect as by remodelling the nose there would be no reason to punish either him or the surgeon on the ground of public interest. Cosmetic [40] operations might be upheld on the ground that everyone is entitled to make himself or herself as attractive as possible.

It is [41] true that consent makes lawful minor non-therapeutic (cosmetic) operations on the individual, such as straightening of teeth, removal of skin blemishes, perforation of the ears and tattooing. Even [42] serious cosmetic operations seems to be justifiable when the object is to remedy a detrimental psychological condition of the patient caused by unsightly outward appearance (e.g. disfigureing due to cancer or an accident.)

(XI.) WHAT FORM OF CONSENT IS REQUIRED:

It is always for the defendant to show that consent has been given. There are no hard and fast rules as to the form of consent which is to be obtained. Consent to surgery need not have to be in writing to be valid. As an oral or implied consent may be difficult to prove most doctors and hospitals prefer a written consent that can be incorporated into the permanent record of the patient.

As a rule express consent whether oral or written is not required for minor procedures, consent being implied as an aspect of doctor patient relationship, allowing such contact as necessary for treatment. In Preston v Hubbel (87 Cal. App. 2d 53) a patient who consented to the extraction of a tooth was held to have impliedly authorised the dentist to repair a fracture which was occasioned without negligence, in extracting the tooth. In McClees v Cohen (1930, 158 Md 60) in an action against a dentist for extracting the wrong teeth the Court said that if the patient had gone to the dentist and submitted herself for diagnosis with the express or implied request that he do whatever was necessary to give her relief, he would only be answerable for the lack of proper knowledge, skill and care in the treatment. Although consent may be implied in the case of minor operations there is no clear guide as to what is a minor procedure and how much consent is implied in the acceptance of treatment. However it is unlikely that a patient who asks a surgeon to treat her is

giving an implied consent to perform a major operation without further consultation.

<u>For there to be a legally valid consent the following conditions must be satisfied</u>.

1) The patient must have the legal capacity to give a valid consent.
2) Patient must know substantially to what he is consenting i.e. the patient's consent must be educated.
3) Consent should be granted freely without force or fraud.
4) Consent given should not be exceeded. (Each of these requirements will be discussed in detail.)

1) <u>Capacity to Consent</u>:

<u>Adults</u>: The normal adult who is compos mentis can give consent himself. A person[43] who has attained his majority and is of sound mind is presumptively qualified to give or withhold consent. The presumption may be rebutted however, by evidence showing that when the consent was given the party was drunk,[44] under the influence of drugs,[45] delirious or comatose[46] or otherwise incapable of exercising rational judgement. If these are the facts law will nevertheless infer consent if the patients life was at stake and there was no one present to give consent in his behalf.[47]

<u>Minors</u>: In the case of children and juveniles, consent should be obtained from the parent or guardian and the age of 16 is established by the legislature as the age of consent and it would seem that a distinction must be drawn between minors who have attained the age of 16 and those who have not: Under the Guardianship Act of 1968 the age of consent is 16. S. 25 of Guardianship Act provides - that consent of or refusal to consent by a child over the age of 16 years to any donation of blood or to any surgical, medical or dental procedure, shall be valid as if the child is of full age. Thus if a child of 16 or over refuses treatment to which his parents consent then a doctor will be liable to an action in battery, at the suit of the child, if he performs treatment.

Does this section mean that a child over 16 and under 21 is competent to consent to a major operation, which requires a far more mature intellect than is required to consent to treatment of a minor character without also obtaining the consent of the parents or guardian? Does it also mean that a minor (between

16-21) can consent to an operation which is not for his benefit? Can a surgeon, who performs an operation not for the minors benefit (such as taking a skin graft) rely upon the minor's consent as a defence? (The latter question is discussed in detail in connection with transplant procedures.)

My submission is that a surgeon or physician should in any event be able to rely upon the child's consent (who is above the age of 16 and under 21) as a defence only where he performs the operation or administers the treatment in the interests of the child's own health. Also I submit that in the case of children between that age group, consent of the child as well as that of the parent should be made necessary, when the operation is of a serious nature.

When a child is too young to give consent, consent of the parents is necessary in almost all situations. S.25 (3) of the Guardianship Act specifies who may give consent to operations upon their children. Those specified in the section are the guardian of the child or if there is no guardian person acting as the parent or if there is no such person, a Magistrate or the Superintendent of Child Welfare. However, it must be stressed neither the consent of the child or his parent or guardian is necessary, in an emergency.

The circumstances may arise, when consent by a parent for the transfusion of a child, is unreasonably withheld because of religious belief of the parent, that the use of blood for therapeutic purposes is wrong. In a situation like this the physician would be faced with the problem of a child requiring transfusion and parents refusing authority for the use of the life saving measure because they belong to the sect of Jehovah's Witnesses or some other religion which hold similar views.

If a doctor proceeds to give the transfusion in such circumstances he must risk the legal consequences. He has the defence of emergency against a civil action. If the transfusion is merely desirable but if there is no immediate danger, then this defence of emergency would not be available to him. If he fails to give blood and the child dies, his fear of a civil action would not be accepted as a sufficient duress to make him refrain from doing what he knew would probably save the life of the child. Case of R v Senior (1899 1 Q.B. 283) would show

the laws attitude towards parents who deny their children necessary medical treatment on religious grounds. In this case the child died through such neglect and father was convicted of manslaughter.

If the patient is at home and under the control of the parent it will be difficult to give him necessary treatment. It is clear in such circumstances a parent's refusal to consent to a transfusion run contrary to the parental duty at common law to protect and care for their children. In England the only course open was to make an application by the Local Authority under S.62 of Children and Young Persons Act 1933 to have the child removed from his parents control as being in need of care and protection. Although this is not a purpose envisaged by the Children and Young Persons Act in England it has been adopted as a life saving measure.

In the United States, many States have statutes which authorise the Juvenile Courts to order necessary medical and surgical care, if parent or guardian refuses to provide it for a minor child. e.g. treatments and procedures such as blood transfusions and straightening of legs have been ordered by Courts. The attitude of the Courts in America is well summed up by the United States Supreme Court in Prince v Commonwealth (321 U.S. 158, 170 (1944)) as follows - 'parents may be free to become martyrs themselves. But it does not follow that they are free in identical circumstances to make martyrs of their children before they reach the age of full and legal discretion, when they can make the choice for themselves.'

<u>The question to be considered here is whether a doctor in New Zealand who administers a transfusion under such circumstance would be protected from civil or criminal liability by S.126 (B) of the Health Act 1956.</u>

It is clear that this provision gives protection to a medical practitioner (for administering a blood transfusion to a minor without the consent of those whose consent is required by law) only

1) if the doctor forms a reasonable opinion that the transfusion is necessary to save the life of the patient in the circumstances, 126 (b) (3) a, and reasonable attempts were made to get such consent S.S. (3) b i or

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it was impracticable in the circumstances to get such consent S.S. (3) b ii, and it was reasonable in the circumstances.

However, it is clear in a situation like this, that a doctor will not be in a position to satisfy the condition required under S.S.3 (b) because it is apparent that the parents are available and that they have refused to consent to the transfusion.

Finally with regard to minors the question arises, whether a doctor, who performs an operation on a minor with consent of a person whom he bona fide believes to be the guardian or to have sufficient authroity from the guardian, is protected from liability.

There is no direct decision on this point. The American case of Rishworth v Moss (1913 159 S.W. 122) gives an indication of the attitude the Courts may adopt. In this case, a child of 11 years who was sent by her parents to spend a holiday with her 2 unmarried sisters was operated for removal of her tonsils and adenoids. American Courts dealing with the question according to strict principles of law of Agency, held that a surgeon could rely upon the girls' consent to the operation only if the parents had either given actual authroity to the girls to consent on their behalf or has conducted themselves in such a way as to make the surgeon believe that the girls had their authority to consent. In reality no actual authority had been given and Courts held that the fact that parents permitted the child to visit the sisters could not justify the surgeon in inferring that authority had been given to them to consent to such a serious operation. Thus, it is clear from this decision that a doctor will be protected by the consent of a person other than the guardian only if that person had actual authority (whether given expressly or by implication) from the guardian to consent to such an operation or has been placed by the guardian in such a position as to justify the doctor in believing that the authority has been given.

But if a person induces a doctor to operate on a minor child by representing that he was the infant's guardian then in such a case the doctor should have a remedy against that person who induced him.

Persons of Unsound Mind:

A mentally ill person may or may not be able to give a valid consent to treatment depending on his mental state.

If a person is compulsorily admitted for treatment (under S.25 of Mental Health Act) consent of the patient is not required and the consent of the Medical Superintendent who has custody of the patient will be sufficient for purpose of medical treatment. If the patient is voluntarily admitted then consent of the patient is required to any treatment, as if he were a patient in an ordinary hospital and a child who is over 16 years of age who is capable of expressing his own wishes may make such arrangement with the Superintendent for treatment notwithstanding any objections from his parents or guardians.

What is the position with regard to mental patients who are not in hospital or those admitted for observation who are not capable of understanding the nature of treatment or the effect of consent?

The legal position is that the doctor must obtain the consent of the nearest relative. However, it must be noted that Stephen's Digest of the Criminal Law(48) contains the following submission that if "a person is in such circumstances as to be incapable of giving consent to a surgical operation ..... it is not a crime to perform such an operation ..... without his consent or in spite of his resistance."

A problem which does not appear to have been dealt with in any of the English or American cases is whether upon the incapacity of one spouse, his or her rights of giving consent automatically passes to the other spouse. Would the doctor be liable if he operates without the spouse's consent?

In the American case of Pratt v Davis ((1905) 118 Ill app. 161) a similar problem arose. However, it does not provide a conclusive answer to the question. The defendant operated on the plaintiff's wife for removal of her uterus and ovaries without consent and the husband sued the doctor on behalf of the insane wife. Defendant alleged that the plaintiff was insane at the time of the operation and that he obtained the husband's consent. However, the Court found that the husband had not consented and gave judgement for the plaintiff. In the Appellate Court - delivering the

judgement Brown J. pointed out that he entertained some doubt as to the correctness of the assumption that the wife being insane and there being no other legally appointed guardian the husband was solely in control of her person.

However, Nethan[49] thinks, in such circumstances proper inference to be drawn from the relationship of husband and wife is that each gives to the other an implied authority to grant or withhold consent.

Spouses:

Where a patient is married it is not legally necessary to obtain the consent of the spouse provided the patient is of sound mind and conscious. In Rosenberg v Feign (1953 119 Cal. App. 2d 783) where a physician was held not liable to the husband of a woman whom he had treated with her consent, though the treatment resulted in a miscarriage.

Where an operation is medically necessary for the wife husband cannot prevent the operation by withholding his consent. Janey v Housekeeper (70 MD 162 16 A 382 (1889)).

Therefore we may conclude that neither spouse can complain that his or her rights have been infringed by the performance of an operation on the other, if the operation was performed with the patient's consent and was performed bona fide in the interests of the patient on medical grounds.

However, in some circumstances, consent of both spouses must be obtained before an operation is performed on one of them, i.e. a doctor could be held liable in damages for operating upon a spouse who is capable of consenting and does consent to the operation, if the consent of the other spouse has not been secured to the operation.

A doubtful issue is in the case of an illegal operation (abortion or sterilisation) to which the wife has consented. It is submitted that in these circumstances the husband could sue for loss of his wife's services, since the operation is wrongful, despite the wife's consent and the wife's consent only bars her action and not her husband's completely separate claim. However, a wife has no corresponding claim in respect of a loss of her husband's society. Best v Samuel Fox (1952 AC 716).

However, Nethan[50] thinks that 'an action should lie in respect of a loss of consortium only when the husband is deprived of all the rights which together make up the consortium and that no action lies therefore when consortium has merely been impaired by reasons of some interference with the wife's sexual capacity'.

2) Knowledge of the plaintiff, i.e. Patient's consent must be 'educated'.

If a doctor or surgeon obtains consent to treatment by concealing dangers inherent in the treatment he may become liable in battery because the apparent consent he obtained is not a real consent. He may also become liable in negligence, for breach of his duty towards his patient, if a patient can prove that the nature of the treatment was not explained to him and that a reasonable doctor using the skill of his profession would have given him the information he lacked. In the case of Smith v Auckland Hospital Board (1965 N.Z.L.R. 191 (C.A.) the doctor failed to answer the questions put to him by the patient as to the risks involved in the procedure recommended by him and as a result of submitting to treatment the patient suffered a surgical mishap. The Court of Appeal reversing the judgement of Woodhouse J. in the S.C. held the particular relationship of doctor and patient is sufficient to impose upon the doctor a duty to use due care in answering a question put to him by the patient where the patient, to the knowledge of the doctor intends to place reliance on that answer in making a decision as to a treatment to which he is asked to consent. Hedley Byrne and Co. Ltd. v Heller and Partners Ltd. (1964 A C 465) applied.

The Court further held, that if in answering such a question the doctor fails to use due care and as a result of submitting to the proposed treatment the patient suffers injuries, the doctor will be liable to the patient in negligence if the evidence shows that it is probable that if a proper answer had been given patient would have refused to undergo treatment.

Thus, in an action in negligence plaintiff must show that he suffered damage and he must also prove that if he had known what was involved in the treatment he would not have consented. However, in an action in battery although it is not necessary to prove damage plaintiff must prove that he was materially deceived about the nature of the operation.

Even though a patient signs a written consent he may not

always be held to it, when he did not know or understand to what he was consenting. The English Medical[51] Defence Union Booklet states "It is essential that the nature and the effect of the operation are explained to the patient. Unless this is done he may afterwards repudiate the consent form on the ground that he did not fully understand the document which he signed." When the patient signs a consent form the onus is usually on him to show that he was deceived.

Courts in other jurisdictions have been placed in the position of having to decide the question whether the consent should be binding when the patient does not consciously weigh the risks of undergoing treatment against risks of foregoing treatment. A patient's decision to undergo the treatment in spite of the risks inherent in the treatment is the product of 'informed consent'. However, the average patient's ignorance of medical science very likely make him unaware of particular risks inherent in a proposed treatment and hence prevents him from giving the informed consent which the law requires. Informed consent therefore concerns the extent to which a doctor must disclose risks inherent in a proposed method of treatment.

It is necessary at this point to examine how the Courts in other jurisdictions have approached the problem. In the past decade the American Courts have evolved several standards for the degree of education to be given a patient before he can be said to have consented to the surgery or treatment. In some of the cases Courts have followed the professional standard in determining whether there was a duty to disclose a given risk. In Salago v Leland Stanford Jr. University Bd. of Trustees (154 Cal. App. 2d 560, 578) the California Court stated a strict standard for the degree of education to be given a patient before he can be said to have consented.

'A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment and likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent ..... patient's mental and emotional condition is important and in certain cases may be crucial and that in discussing the element of risk, a certain

amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent.'

Although Courts of other States too have stated the principle that the patient must have knowledge of what he consents to, they do not require such a strict standard as the California Court requires. American Courts have on the whole preferred to treat 'informed consent' cases as actions in negligence rather than battery. In the American case of Bowers v Talmage and Vonstorch (1963 So 2d, 888, 889) where a 9 year old boy who suffered from hallucinations was taken to a neurologist who recommended an arteriogram an exploratory process (in which 3% of the cases were known to result in serious injury) who was in doubt as to whether the child's trouble was emotional or organic. However, the defendant did not explain the risks involved in the treatment to the child's parents and they gave their consent. Also, there was no emergency requiring the operation. As a consequence of the treatment plaintiff was partly paralysed. Court held on appeal 'unless a person who gives consent to an operation knows its dangers and the degree of danger, a consent does not represent a choice and is ineffectual.'

In this case Court observed that the doctors primary duty is to do what is best for the patient and any conflict between that duty and that of making a frightening disclosure ordinarily should be resolved in favour of the primary duty.

In Watson v Cluffs (136 S.E. 2d 617 (1964)) the doctor told the patient that she would have to stay in the hospital for a week before the serious operation. She suffered paralysis of both vocal cords as a result of the operation and had to have a tracheotomy. The plaintiff lost in this case on the informed consent theory. The North Carolina Court stated 'the type of risk involved should have a bearing on the completeness of the disclosure required .....But a surgeon except in emergency, should make a reasonable disclosure of the risk involved ..... if the operation involved known risks.'

In Mitchell v Robinson (79 A L R 2d 1017 (1960)) the plaintiff underwent insulin shock treatment for severe depression and anxiety complicated by alcoholism. He consented orally to the treatment. Although it was not immediately necessary to save his life it was carried out by qualified doctors without

negligence. In the course of the treatment, plaintiff suffered fractured vertebrae, during a convulsion, though all reasonable precautions had been taken to prevent this. Plaintiff brought this action on the ground that he had not been informed of the risks and dangers involved in the treatment and that doctors had been negligent in not giving this information. In this case medical evidence was given that shock therapy carried a high risk of fracture - one doctor assessed it at 18%. The Court held in the circumstances the physician had a legal duty to inform the patient of any serious risk of collateral injury arising from any new and radical procedure he might prescribe and that a prima facie cause of action in negligence was established.

In another American case Yeats v Harms (193 Kan - 320, 327) the Court affirmed a jury verdict for defendant, where the injury complained of (i.e. loss of an eye due to infection following cataract surgery) was from a risk not disclosed. The defendant testified that such results occurred in 1½% of the cases he treated. According to the Kansas Court - they will not 'extend the duty of a physician or surgeon to the extreme when he would have to appraise his patient not only of the known risks but also of each infinitesimal, imaginative or speculative element that would go into making up such risks.'

It would appear from the foregoing cases that the requirement of informed consent is applied most strictly, when a Court feels that the procedure involved is so new or so radical that the patient should be given adequate explanation to enable him to decide whether he would rather forego the treatment than submit to the risk.

English Approach:

In a recent English case Bolam v Frierd Hospital Management Committee (1957 1 WLR 582) a patient suffered a fracture of the pelvis while undergoing electric convulsion treatment. He brought an action for negligence and breach of duty alleging that he was not given his warning of the risks involved in the treatment. In this case McNair J. directed the jury as follows - 'Members of the jury, though it is a matter entirely for you, you may well think that when dealing with a mentally sick man and having a strong belief that his only hope of cure is E.C.T. treatment, a doctor cannot be criticised, if

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he does not stress the dangers which he believes to be minimal involved in that treatment.' He also advised them that the plaintiff had to satisfy them that he would not have taken the treatment, if he had been warned, as otherwise the lack of warning made no difference to his position and caused him no damage. The jury found for the defendants. However, this case could be distinguished from the American case of shock treatment discussed above, where the plaintiff recovered damages, because in the English case the patient was mentally ill and shock treatment was the only cure. The risk of fracture in the English case was one in 10,000 whereas it was put at 18% in the American case. The doctor was held justified in not advising him of the risks which would only have made him apprehensive.

In another English case Hatcher v Black (1954 The Times July 2nd) where a surgeon was held not to have been negligent in failing to warn a nervous patient of a slight risk to her vocal cord, involved in an operation for a toxic goitre. In this case the doctor told the patient the possible alternative treatment - namely an operation or medical treatment by drugs and pointed out that treatment of drugs would take a long time. Patient chose the operation and in the course of the operation her left laryngeal nerve was injured and the left vocal cord was paralysed. Denning L.J. in his summing up to the jury said 'What should a doctor tell a patient? The surgeon has admitted that on the evening before the operation he told the plaintiff that there was no risk to her voice when he knew that there was some slight risk but that he did it for her own good, because it was of vital importance that she should not worry ..... he told a lie but he did it because in the circumstances it was justifiable .... But the law does not condemn a doctor when he only does what a wise doctor so placed would do.' Jury returned a verdict in favour of the defendants.

<u>What conclusions can be drawn from these cases, as to the extent of medical mans duty towards the patients to disclose risks so as to elicit an informed consent?</u>

It appears from these cases that English Courts are more ready to accept a surgeon's opinion that a patient ought not to be told than the American Courts. However, it should be noted that this deprives the patient of his right to decide

what should happen to him. It is submitted that the laws strong predisposition towards personal control over bodily invasion has been violated by the current judicial treatment of informed consents and that it encourages medical men in their conspiracy of silence. The laws predisposition towards patient's rights could be more effectively served if the problem were treated in the following manner. --

i.e. A surgeon should be under an obligation to make a full disclosure of all known material risks in a proposed operation or course of treatment except for those risks of which the patient is likely to know (i.e. risks that are common to all the operations e.g. risk of infection during major surgery or risks involved in anaesthesia etc.). But if the doctor makes any lesser disclosure then he must prove the reasonableness of such disclosure or the immateriality of the undisclosed risk.

Some patients may not want to know the risks and would prefer to entrust themselves to the doctors best judgement. While such patients do exist it cannot be assumed that all patients feel that way. Therefore a doctor should proceed on the assumption that a patient wishes to know the risks unless in response to an offer of disclosure, he declines or delegates his decision to the doctor. Under the above mentioned proposed standard there would be 3 defences available to the doctor when a plaintiff alleges that there was a failure to inform the risks involved in the proposed treatment and that he would have refused to consent had he known the risks.

1) The physician's first defence would be the immateriality of the risk. The doctor can accomplish this by showing through expert testimony that the risk was so minor or infrequent that knowledge of the risk was not essential to an intelligent consent or was so difficult to explain that it would place an unreasonable burden upon him to inform every patient the risk.

2) Secondly, a doctor could prove that he was not and should not have been aware of the risk. If the risks are not known, there should be no liability for failure to disclose, unless physicians lack of knowledge of the risk was itself negligent,

or thirdly, a physician could prove that the patient's mental or emotional condition was such that it would have been therapeutically unwise to inform the risk. But safer course for physicians, when disclosure should not be made for the benefit of the patient would be, to disclose the risks to the responsible relatives. In Lester v Aetna Cas. and Sur. Co. (240 F2d 676, 679 (1957)) it was held that an adequate disclosure of the risks in shock therapy to the wife of the patient was sufficient. In this case wife and physician had agreed that it would be best not to frighten the patient by disclosure of the risks.

3) Consent must be freely granted and must not be obtained by force or fraud.

If a doctor obtains consent by force or fraud then patient's apparent consent to the operation or treatment will afford no defence to an action for assault. To represent to a patient that an operation is necessary to save life or to preserve the health when that is not the case or to indicate that it will give greater relief than there is any reasonable prospect of obtaining is to perpetrate a fraud on the patient which vitiates (52) consent. However, fraud vitiates consent only if it relates to the substance of the treatment. In Hobbs v Kizen (1966 236F 681) consent given by the patient was vitiated when the doctor performed an abortion on her under the pretence that he was operating for an abscess on the womb.

4) Consent must not be exceeded.

A medical man who goes outside the scope of the consent which has been expressly or impliedly given is liable to the patient for an assault; just as a doctor who operates on a patient without his consent.

A heavily litigated area in medical-surgical consent is the situation when the physician extends the treatment beyond that which is specifically authorised. As in the cases (discussed in connection with the defence of emergency) the existing danger to the life or health of the patient is often the determining factor. Thus, where consent to a certain operation has been given and in the operation serious conditions not to be anticipated are discovered endangering the life or health of a patient, the surgeon is justified in extending the operation

to remove such conditions.

See Mohr v Williams ((1905) 104 N.W.)

In another American case Tabor v Scobee (254 S.W. 2d 474) a physician performing a caesarean operation tied off the patient's fallopian tubes in order to preclude a second pregnancy when he found tumours which he felt might be dangerous in the event of such pregnancy. It was held that he was liable for assault; the Court holding, that there was no emergency immediately threatening the life or health, pointed out that the fact that it was more convenient to perform the operation at that time rather than later after a consultation with the patient did not justify the action, even though the operation was skilful and not negligently performed. However, in the Canadian case of Marshall v Curry (1933 DLR 260) the doctor engaged to perform a hernia operation was held to have been justifed in removing the plaintiff's testicle when in the course of the operation he found conditions which indicated that removal was required not only to repair the hernia but also to protect the patient's life and health.

In the recent American cases, there is a tendency to evolve a test of general consent to deal with these cases because it is thought that surgeons should be given some latitude in operations as to not unduly restrict them when an obvious danger may be extinguished by an extension of the present operation. A case in which the application of the new test can be seen is Kennedy v Parrot (1956 243 NC 355).

The rule is that a patient's consent to an operation in the absence of proof to the contrary will be construed as general in nature and the surgeon may extend the operation to remedy any abnormal or diseased condition in the area of original incision, when ever, he in the exercise of his sound professional judgement determines that correct surgical procedure dictates and requires such an extension of the operation originally contemplated.

Kloss[53] says that the recent trend in American Courts is an extension of the emergency principle to cases, where, though no emergency exists, it is reasonable for the surgeon

to remedy a condition without asking further permission, i.e. surgeon is only liable for exceeding consent when he does so unreasonably and so negligently. In this case surgeon while performing an appendectomy discovered cysts on patient's ovary and although no emergency existed considering them a potential source of danger punctured them. Patient developed phlebitis and plaintiff claimed that it was caused by the unauthorised puncture. The Court held that the surgeon was not liable as he had taken all reasonable care nor was he liable in battery for 'where an internal operation is indicated a surgeon may lawfully perform and it is his duty to perform such operation as good surgery demands, even where it means an extension of the operation further than was originally contemplated and for so doing he is not to be held liable in damages as for an unauthorised operation.'

However, it must be noted that the rule depends on general consent being implied. Therefore if the patient expressly forbade the surgeon to exceed the consent, he will be liable in battery if he disregards the instruction. In Marshall v Harter (262 S.W. 2d 180 (ky 1953)) the patient submitting to the examination had told the doctor there was to be no cutting. The doctor claimed that he explained that the examination would not be complete unless a biopsy was obtained and the patient had consented to that. The Court held that the patient had a ~~course~~ cause of action if he so told the doctor even if the doctor's act was good medical judgement and the plaintiff suffered no permanent or severe harm. This is why writers say that Beatty v Cullingworth (1896 B.M.J. 1546) the only English case on the subject was wrongly decided. In this case although the patient instructed the surgeon not to remove both ovaries, surgeon found both ovaries diseased (during the operation) and removed both. It was held that it was legally justified.

However, a physician should carefully consider any extension of an operation specially where the result will deprive the patient of the possibility of having children. In such cases surgeon should undertake such procedures without consent, only if the patient's condition makes it necessary for preservation of her life and health and not merely because it is advisable.

Therefore in conclusion it can be said that the surgeon may operate without prior authorization if an emergency demands

it or if it is reasonable in the circumstances for him to go beyond express or implied consent of the patient (except where reproductive function of the parties are concerned.)

(XII.) CONCLUSIONS:

Consent to medical treatment may be implied by lying on the examination couch, baring the arm for injection or by submitting to the preparation for operation. But it would be unreasonable to expect a physician to obtain the patient's written consent to the thousands of minor medical procedures which are carried out daily in hospitals. But if a major surgical operation is contemplated it should be the universal practice to insist on written consent to the proposed procedure provided that a patient is in a condition to give it.

Saving the life of the patient should always be the paramount consideration and in an emergency doctor should take such steps however drastic as he considers necessary (to save the life of the patient) without being hampered by the delay in obtaining the consent of a relative, when the patient is a child or unconscious.

The age of 16 is established by the Legislature of New Zealand as the age of consent and under the age of 16 excepting in emergency the consent of the parent or guardian must always be sought. The capacity of a mentally subnormal person should be qualified by the degree of understanding; if he can comprehend the proposed procedure then there need be no reference to his relatives. The same should apply to a mentally ill person. With a compulsorily detained patient, no consent other than that of the person responsible for her treatment of the mental condition is required although it is wise to communicate with relatives when it is possible. If capacity to give consent is temporarily impaired by drink or drugs the doctor should be allowed to use his own judgement as to the extent of his treatment, confining this to measures to save life or prevent serious permanent damage until patient is in a condition to appreciate what is to be done.

Then as to the degree of education to be given a patient before he can be said to have consented to the treatment the standard proposed above (when discussing this) should be observed by the doctors.

With regard to married couples in general, the spouse has no right to interfere with the treatment of his or her partner. But I think it is wise to put the other in the picture, unless the patient expressly forbids this. If there is to be interference with reproductive function as when the womb is to be removed or a vasectomy operation is to be performed, both partners must be fully appraised of the situation and both should be required to give written consent. (This is the practice followed in New Zealand hospitals.)

Except in emergency written consent to operation or anaesthetic should always be obtained. These should be retained with the clinical records of the patient. It is also important that signature should be countersigned by the surgeon in charge after the explanation of the procedure; the practice of asking a patient to sign an incompleted form like a blank cheque, on admission to the hospital before exact nature of the operation has been settled is reprehensible. If it is impossible to forecast the extension of an operation until it has been commenced the patient should be warned and sanction obtained to such measures as may reasonably be expected to become necessary.

It is hoped that the examination of the practice followed in other jurisdictions with regard to medical responsibility in this respect might be found of interest and use in the medico-legal practice in New Zealand.

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FOOTNOTES:

(1) Ethics in Medical Progress P.82

(2) Consent to Medical Treatment - Diana M. Kloss 5 Medicine Science and the Law. P.92

(3) Lord Devlin - Samples of Law Making P.87

(4) Lord Devlin - Samples of Law Making P.89

(5) Salmond and Torts 11th edn. P.42

(6) Windfield - Province of the Law of Tort. P.86-91

(7) D.W. Meyers - The Human Body and the Law P.1.

(8) 26 M.L.R. 232

(9) Gordon - Criminal Law of Scotland P.351

(10) Quoted from 1970 N.Z.M.J. 230

(11) Samples of Law Making P.94

(12) 1966, British Medical Journal 1, P.1597

(13) Gordon - Criminal Law of Scotland P.775

(14) D.W. Meyers - The Human Body and the Law P.15

(15) Williams - Sanctity of Life P.106

(16) See Ward v Ward 1958 1 WLR 693; Forbes v Forbes 1955 1 WLR 531

(17) 81 S.A.L.J. 1964 P. 191 (S.A. Strauss)

(18) Obtained from the Wellington Hospital

(19) 1970 N.Z.M.J. P.231

(20) Adams - Criminal Law and Practice in N.Z. (1964 ed.) P.129

(21) Glanville Williams - Consent and Public Policy 1962 C.L.R. 159

(22) Professor G.P. Barton - Legal Aspects of Transsexualism and Sex Re-assignment P.17

(23) It appears from the judgement of Omrod J. in Corbett v Corbett 1970 2 WLR 1306 1318

(24) Reported in the Argentina Law Journal and commented upon exclusively by S.A. Strauss in 84 S.A.L.J. 1967 P. 214

(25) Meyers - The Human Body and the Law P.66

(26) Transsexualism 1971 Cornell Law Review Vol. 56 P.974

(27) Professor Barton - Legal Aspects of Transsexualism and Sex Re-assignment P.18

(28) Professor Barton - P.19

(29) Meyers - P.121

(30) Meyers - P.122

(31) Forbes - Legal Aspects of Blood Transfusion and therapy in general - 4 Medicine Science and the Law (1964) P.26

(32) Meyers - 122

(33) Ethics in Medical Progress - 214

FOOTNOTES (contd.)

(34) Shapiro - Organ Grafting in Man 14 Journal for Med. 41 (1967)

(35) Danbe - Ethics in Medical Progress 195

(36) These cases have not been officially reported but have been discussed by Curran in N.Y. 34 U.L.R. 891

(37) Meyers - 132

(38) 81 S.A.L.J. 1964 P.189

(39) 1962 C.L.R. 155

(40) 1962 C.L.R. 157

(41) 81 S.A.L.J. 344

(42) 81 S.A.L.J. P.189

(43) Meek v City of Loveland 85 Colo. 346

(44) Barker v Heaney 82 S.W. 2d 417

(45) Wheeler v Barker 92 Cal. App. 2d 776

(46) Arbalo v Nealson 73 Cal. App. 2d 545

(47) Stetler and Moritz - Doctor, Patient and the Law P.134

(48) Stephens - Digest of Criminal Law - 6th ed. (1904) 164 Art. 226

(49) Nethan - Medical Negligence 169

(50) Nethan - Medical Negligence P.181

(51) 5 Medicine, Science and the Law P.92

(52) Stetler and Moritz - P.134. Doctor, Patient and the Law

(53) 5 Medicine Science and the Law P.100

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