

CHAPTER 5

Physician's duty to inform

1. Introduction

A legal duty rests on all medical professionals to fully inform their patients about the nature and extent of any medical procedure planned for the specific patient.¹ This information is necessary to enable a patient² to make a rational choice whether or not to proceed with the proposed medical intervention³ and then to give the required informed consent thereto.⁴ This principle is trite law in legal systems all over the world.⁵ Van Oosten⁶ remarks that in terms of

¹ Van Oosten, F.F.W. 1995. *Castell v De Greef and the Doctrine of Informed Consent: Medical Paternalism ousted in favour of Patient Autonomy*. *De Jure* 166.

² Clarke, 1994. **Genetic Counselling - Practice and Principles: Professional Ethics** Routledge, draws our attention to the fact that "the persons seeking information are usually known as 'clients'; the word 'patient' would suggest that they were suffering from a disease, which is very often not the case." - because either the parents or their children are in fact affected by genetical abnormality in wrongful life litigation, both the terms patient and client are used in this study.

³ or rather choose an alternative procedure.

⁴ see *infra* on the requirements for lawful consent.

⁵ for references to the same position in other countries, see:
Harrer, H. 1994. Aspects of Failed Family Planning in the United States of America and Germany. *The Journal of Legal Medicine* (15), 112: "On the other hand a surgeon may be liable if a procedure is undertaken without the patient's valid 'informed consent', in other words, in violation of the patient's right to self-determination." and also
Leenen, H.J.J. 1994. **Handboek Gezondheidsrecht, Deel I: Rechten van mensen in de gezondheidszorg** Tjeenk Willink, Alphen aan de Rijn (3de druk), 162.
Legemaate, L. 1997. Het recht van de patiënt op informatie, mede in relatie tot de dossierplicht van de arts. *Advocatenblad* (77:5), 202;
Earle, M. 1995. 'Informed consent': Is there room for the reasonable patient in South African Law? *SALJ* (112), 629: "Within medical practice, a patient's informed consent is necessary for the physician's actions to be legal, but different jurisdictions interpret the doctrine of informed consent differently."
see, however, Strauss, S.A. 1991. **Doctor, patient and the law** JL van Schaik, (3rd Edition), 15: "As a point of departure it may be stated that the doctor's duty of disclosure to the patient is a relative one only. On the basis of case law as it has evolved in a number of countries, including South Africa, it can be said that there is no absolute duty on the doctor to inform the patient on all aspects of his examination, the findings made in the course of the examination, the doctor's diagnosis, the treatment given or envisaged and the general prognosis."

⁶ *op cit* p 166.

both the South African law of contract⁷ and delict, a patient's proper consent is fundamental to lawful medical intervention.⁸

"In fact, barring special circumstances, such as emergency situations, statutory authority and, conceivably, authorisation by the court, the general rule is that in the absence of lawful consent of either the patient personally or someone acting on his behalf, medical interventions are wrongful or unlawful."⁹

This aspect of forensic medicine is of great relevance to the study of wrongful life litigation. In a wrongful conception action, the plaintiff would typically argue that the physician neglected to inform him of the known failure rate for the particular sterilization procedure, or failed to warn of possible natural reversal or about more assured alternatives, or failed to advise that additional contraceptive measures should be used until the success of the intervention has been established beyond any doubt *et cetera*.¹⁰

In wrongful birth and wrongful life actions various possible information breaches could occur.¹¹ A physician could neglect to inform a patient in a high-risk group of genetic disease of available genetic tests or a genetic counsellor could have omitted to properly inform a client about the actual risks of a planned pregnancy *et cetera*.

It is important to note that, as the medical professional's duty to inform his patient will be discussed comprehensively, one should distinguish between the varying focuses/ aspects discussed from time to time. Concomitant issues will also be addressed, such as the boundaries of people entitled to receive genetic information, the influence of subjective viewpoints of the medical practitioner on the effective provision of information, the specific duties of genetic counsellors regarding procreative decisions and so forth.

1.1 Background

⁷ see *infra* where the contractual relationship between physician and patient is discussed.

⁸ **Palmer v Palmer** 1955 (3) SA 56 (O), **Correia v Berwind** 1986 (4) SA 60 (Z) and **Administrator Natal v Edouard** 1990 (3) SA 581 (A).

⁹ Van Oosten *op cit* p 166.

¹⁰ for specific references and case law, see ch 6.

¹¹ for specific references, see ch 7 and ch 8.

Earle¹² writes that the doctrine of informed consent initially came from America and was only later-on embraced by certain Commonwealth countries.¹³ He notes that legal consent has attached to it facets of contract. This contractual basis and freedom of agreement has been highly esteemed since Roman law times and confirms the concept of freedom of will.¹⁴

Wear¹⁵ writes:

"The law regarding informed consent varies across jurisdictions and countries, so in a global sense there is no single and settled sense of the law to explicate, not even on the level of basic principles and criteria."¹⁶

Bensing¹⁷ reflects the importance of communication between physician and patient in the medical sphere. Special reference is made to the significance of proper information as invaluable assistance in making an accurate diagnosis. Bensing¹⁸ elevates the value of good communication above technological advances as instrument for physicians:

"De gebruikelijke omschrijving van geneeskunde als een combinatie van kunst en kunde wordt hiermee uitgebreid met een derde factor: communicatie. Het is terecht dat communicatie op deze manier expliciet onder de aandacht wordt gebracht. Immers, communicatie - het uitwisselen van informatie en emoties - is het belangrijkste instrument van de arts. Belangrijker dan diagnostische hulpmiddelen, en belangrijker dan technologische interventies, al doet de coalitie van media, medische wetenschap, en industrie ons graag anders geloven."

¹² op cit p 630.

¹³ he is of the opinion that this was not the case in England and South Africa - see *infra* for a different viewpoint.

¹⁴ "In medicine, one can detect a move away from the prior, tacit or general consent described by classical liberalism to a more specific consent for each procedure, as well as a duty of information, which is in part due to the increasing complexity of medical procedures." - *ibid*.

¹⁵ 1993. **Informed Consent: Patient Autonomy and Physician Beneficence within Clinical Medicine.** Kluwer Academic Publishers, vol 4.

¹⁶ op cit p 5.

¹⁷ Dokter, H.J. and de Graaf, W.J. 1994. **Arts - Patiënt Interactie: Boerhaave Commissie voor Postacademisch Onderwijs in de Geneeskunde-Rijksuniversiteit, Leiden - Arts-Patient Communicatie: De rol van Affectief Gedrag**, 1.

¹⁸ *ibid*.

McLean,¹⁹ on the other hand, focusses on the clear connection between technology and the duty to inform. She believes that the technical revolution has had a significant consequences for doctors and patients - "as the gap in technical skills widens, so the difficulties of communication inevitably increase". The development of medical science has therefore increased the importance of proper communication of information.

2. A comprehensive disclosure of information

Beer²⁰ reports on liability based on a lack of informed consent as a separate ground of medical negligence law:

*"Een aparte vorm van aansprakelijkheid is die welke saamhangt met het ontbreken van 'informed consent' in het kader van een medische behandeling. Onder het begrip 'informed consent' wordt verstaan de door de patiënt voor medische behandeling gegeven toestemming die is gebaseerd op voldoende en zorgvuldige informatie die van de arts is verkrygen."*²¹

Non-compliance of the duty to inform could have far-reaching implications for a medical practitioner,²² as a patient is then unable to give his permission for the proposed medical intervention.²³ Legemaate²⁴ declares that it is of vital importance that a patient should be informed of the following relevant aspects²⁵ concerning his/ her specific condition or request²⁶

¹⁹ 1989. *A Patient's right to know - Information Disclosure, the Doctor and the Law* Dartmouth - Medico Legal Series, 4.

²⁰ 1991. *Aansprakelijkheid voor Medische Fouten: Vanuit Juridisch oogpunt gezien* Koninklijke Vermande BV. Lelystad, 12.

²¹ A paraphrased summary of this quotation is: Liability for the failure to obtain an informed consent is a separate class of liability found in medical negligence law. Informed consent is the patient's consent prior to medical treatment, based on sufficient and meticulous information supplied by the physician.

²² see fn 7 and also the discussion of the value of proper information *infra*.

²³ Strauss *op cit* p 4.

²⁴ 1996. *Verantwoordingsplicht en aansprakelijkheid in de gezondheidszorg*, W.E.J. Tjeenk Willink, 99.

²⁵ the Dutch statutory regulation found in art. 7:448 lid 2 BW provides that the following aspects should be covered: (compare with the discussion on the proposed comprehensive disclosure discussed on p 5 *infra*).

- *de aard en het doel van het onderzoek of de behandeling en van de uit te voeren verrichtingen;*

and/ or the particular medical procedure or treatment proposed by the physician;²⁷ Legemaate²⁸ identifies a number of variables that could be used as guidelines to ascertain how the duty to inform should be applied in each particular instance:

- does the procedure entail an essential or non-essential intervention?;²⁹
- is the treatment experimental or a non-standard approach?;³⁰
- consideration must be given to the gravity of the risks and its consequences in relation to the frequency of its occurrence;³¹
- was the consequence of the risk a common incident?;³²

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- *de te verwagten gevolgen en risico's daarvan voor de gezondheid van de patiënt;*
 - *andere methoden van onderzoek of behandeling die in aanmerking komen;*
 - *de staat van en de vooruitzichten met betrekking tot de gezondheid van de patiënt voor wat betreft het terrein van het onderzoek of de behandeling.*

²⁶ There are a variety of reasons why a person could decide to consult with a physician. The most obvious reason would be that the patient is ill and seeks medical solace. It also frequently happens that a physician is required to give his expert opinion on a particular health matter, eg to interpret blood test results or maybe give advice to prevent possible future illnesses. Many prospective parents also discuss their future family plans with their general practitioner or a genetic specialist. This is especially true if prospective parents have a tendency/ history of genetic anomalies in their families or are themselves carriers of genetic disease.

The physician's duty to inform his patients will greatly depend on the nature of the consultation. Where it would accordingly be sufficient for a physician to superficially discuss with a flu-patient his condition and the treatment in a few sentences, he would have to be much more thorough and specific if asked to give his opinion to a couple with a high risk of genetic anomaly planning to have a baby. It is lastly essential for a physician to use common layman's language. The patient must be able to understand what will happen, why and when.

²⁷ Van Oosten *op cit* p 171.

²⁸ *op cit* p 100.

²⁹ Legemaate, *ibid* states that although the duty to inform is required in both instances, a more stringent duty is expected in non-essential matters - (Rb Dordrecht 21 juni 1995, *re* a sterilization procedure).

³⁰ *ibid* - it is submitted that a higher level of disclosure is required for procedures of experimental nature.

³¹ *ibid* - all consequences and risks should be disclosed, taking into consideration recurrence and prevalence/seriousness of the danger *ie* a rare occurrence with severe consequences should rather be disclosed than a non-frequent occurrence with moderate effects.

³² *op cit* p 101 - Legemaate reports that some courts have found in the past that certain well-known risks do not fall under the duty to disclose because they are common knowledge (Rb's Gravenhage 21september 1994, failed sterilization operation).

- are there specific circumstances surrounding the patient to be taken into consideration?;³³
- the nature of the intervention in relation to relevant litigious interests;³⁴
- questions by the patient.³⁵

Van Oosten³⁶ similarly reports on the nature and scope of the duty to disclose which is generally expected from a medical professional.³⁷ He distinguishes between disclosure as regards the nature of self-determination information and as regards disclosure of risks and dangers. Concerning the scope of the physician's duty to inform, the following aspects must at least be discussed, although *all* relevant surrounding circumstances should be added:

- the nature of the patient's disease/ condition;
- the nature of the procedure,³⁸ as well as its;
- extent/ scope;³⁹
- administration;⁴⁰

³³ *op cit* p 102 - certain specific circumstances of a particular patient could create a duty to inform of relevant aspects that would not normally fall under a duty to disclose eg in a case where a patient has lost a child due to a serious hereditary disease, the duty to inform such patient of the risk of failure of a sterilization is stronger than normal (Rb Dordrecht 21 juni 1995).

³⁴ Legemaate *ibid*, conveys that in cases where medical interventions take place without the direct goal of healing a patient or improving the service related to the treatment of patients eg organ donation etc, the duty to disclose of possible risks is higher than normal.

³⁵ *op cit* p 103 - the usual disclosure to patients is initiated by the physician and therefore, if a patient pertinently asks for more information, it should be given thoroughly and in detail.

³⁶ 1995 *op cit* p 171.

³⁷ see *infra* - who could fulfill the task of being informers.

³⁸ the nature of the relevant procedure must be explained to the person who will receive the particular treatment, eg whether a patient will be thoroughly examined or merely superficially and specifically whether blood/ cell samples will be taken or whether medicine will be administered etc.

³⁹ closely related to the nature of a medical procedure is the scope or extent of the intervention - a patient must be informed of the magnitude of the intervention and specifically with regard to the extent in which the patient's right to privacy and self-determination will be infringed, thus, whether it will be a trivial or a serious/ dangerous procedure.

⁴⁰ with regards to the administration of treatment or an examination, what needs to be conveyed is the method of application, eg an injection or a tissue sampling, medication applied orally etc.

- importance;⁴¹
- consequences;⁴²
- risks;⁴³
- dangers;⁴⁴
- advantages/ disadvantages;⁴⁵
- alternative procedures;⁴⁶
- prognosis;⁴⁷
- expertise and experience of the physician;⁴⁸

⁴¹ a physician must be sure to explain to the patient the reasons why, according to his expert opinion, a certain intervention will be necessary - if there is reason to believe that a procedure must be performed without delay, this should also be mentioned.

⁴² not only must the reasons and nature of a procedure be explained, but also the effect that the treatment is expected to have on the patient's body and mind.

⁴³ Although the reasonable physician would not disclose very unusual or extremely uncommon risks, *Richter v Estate Hamman* 1976 (3) SA 226 (C), *Lymbery v Jefferies* 1925 AD 236, *dangerous* unusual or remote risks and also dangers *about which the patient makes enquiries*, should however be disclosed.

In terms of genetic research and testing probable risks are often minute, but because the resultant health conditions or consequences are sometimes serious such improbable possibilities should be disclosed. When patients consult with a genetic counsellor for specific genetic advice eg on their particular risk of conceiving an impaired child, it is obvious that all relevant information should be given to those parents and to withhold such information would be breach of contract (positive malperformance) - see ch 2 on contractual liability.

If there are any risks involved with the administration of a procedure it is vital that the possibility of the realisation of such risks be disclosed. An example in the scope of genetics would be that there is an approximate risk of 5% in the administration of an amniocentesis that the foetus could be injured.

⁴⁴ Inherent dangers to a medical procedure (see fn *supra*) must obviously also be mentioned. In this regard a physician would inform a patient considering an amniocentesis that if the foetus were to be injured during the procedure, a spontaneous abortion could take place or that the foetus could be born handicapped as a result. Here it is equally essential that the procedure be placed in perspective in that the dangers that exist if no action would be taken must also be disclosed.

⁴⁵ in order to achieve a fully comprehensive disclosure, it is necessary that the pro's and con's of all possible options available to the patient be mentioned.

⁴⁶ Although the physician's first choice of action must be propagated, it might also be beneficial to the patient if alternative (and maybe less drastic) procedures are given as an option. The final choice is, after all, that of the patient. The patient must be guided in this decision and the reasons why the alternatives would be the physician's second choice must be given.

⁴⁷ Van Oosten *op cit* p 170 - which may include the possibility of subsequent interventions.

⁴⁸ a higher level of proficiency is expected from a specialist - see ch 4 *infra* regarding medical negligence.

- professional personnel, technical resources, degree of specialisation of hospital;
- cost;⁴⁹ as well as
- any other relevant aspect.⁵⁰

3. Who should inform?

With regard to the correct person to inform an individual concerning genetic diagnosis and in the field of clinical genetics generally, the prevailing view is that *treatment* and *genetic counselling* should be provided by different individuals.⁵¹

"The committee would like to emphasise the importance of simple and well-balanced information about the disorder to be detected and about the real significance of carrier status. This is important with regard to obtaining informed consent from the person to be tested."⁵²

Hondius⁵³ debates whether it would be sufficient if a patient is informed by nursing staff and declares that, although such inputs could be of invaluable assistance, it is not acceptable as the only source of information. The physician in question should as a minimum requirement at least act as a co-informer.

"The information to be provided should be the best possible, and it should be conveyed by the health professionals involved. Midwives, gynaecologists, general practitioners and other primary health care workers should possess adequate

⁴⁹ This is an important aspect of *concensus* which is often overlooked or ignored in the scope of medical procedures. The law of contract requires that contracting parties must reach agreement on all the essential aspects of the contract before a legal tie or obligation between the parties is created and a legal, binding contract is concluded. The cost of the proposed medical procedure is very much an essential aspect of their agreement.

⁵⁰ This includes information given to inform the patient of all the relevant aspects of the patient's medical condition and also the medical procedure intended. Based on these facts, the patient then has to make a decision on whether he wants to proceed with the treatment and, if so, with which of the possible treatments available. When the patient gives his consent (based on the information given to him by the medical expert) the physician has legal authority to perform the chosen procedure, in the manner and to the extent the patient consented thereto.

⁵¹ Anon. 1994. Genetic screening. **Report: Health Council of the Netherlands: Committee Genetic Screening** (Publication no. 1994/22E), 51.

⁵² *ibid.*

⁵³ 1995. De privaatrechtelijke positie van de patiënt. In *Europees perspectief. Tijdschrift voor Privaatrecht* (32:4), 1679.

knowledge of the field of genetics. They must subscribe to the purpose and the use of a given test, since the hazards posed by incomplete or incorrect information would otherwise be too great."⁵⁴

Gevers⁵⁵ writes that the provision of genetic advice is not the sole responsibility or monopoly of geneticists. He believes that general practitioners and other specialists also play an important part, especially with regard to the awareness and availability of genetic testing under patients as well as providing information to possibly affected family members.

Eriksson *et al*⁵⁶ gives an illustration of the various parties that could be involved in genetic counselling, indicating the usual course that is followed by an individual seeking genetic advice. He suggests that such an individual could, in the Netherlands, probably find the best assistance at any one of the seven centres for hereditary studies affiliated with the particular universities. These centres are equipped with the best facilities, the most advanced examination techniques and methods and also have computerised information systems. He is of the opinion, however, that all the medical professionals involved with providing genetic information work well together.

*"Het samenspel tussen artsen, specialisten en hulpverleners enerzijds en de ouder- en patiëntenorganisaties anderzijds blijkt goed te werken."*⁵⁷

He⁵⁸ emphasises the important role of the general practitioner in the whole process of genetic counselling,⁵⁹ especially with regard to the initial awareness to possible genetic risk, the availability of genetic tests and also the referral to specialists. Because the general practitioner often has a close relationship with the patient (probably also with the family), and has a detailed medical history and access to other relevant information, he is generally the person in the best position to provide initial assistance.

⁵⁴ Anon. 1994. *op cit* p 65.

⁵⁵ 1987. Juridische aspecten van erfelijkheidsonderzoek en -advies. Verslag: Vereniging voor Gezondheidsrecht (10 April), 8.

⁵⁶ 1985. Over erfelijkheid - aangeboren afwijkingen erfelijkheids voorlichting begeleiding. Bosch & Kenning, 24.

⁵⁷ *ibid.*

⁵⁸ *op cit* p 25.

⁵⁹ see *infra* regarding the various facets of genetic counselling.

4. A duty to inform

The main purpose of the duty to inform is basically to protect the patient's freedom of choice and his right to self-determination by placing the patient (as a layperson) in a position to make a rational decision based on knowledge and appreciation of his medical situation.⁶⁰ In absence of such information, real consent will be lacking.⁶¹

Legemaate⁶² conveys that the patient's right to information is also a fundamental right in Dutch law and is not only well established in professional codes, rules of conduct, criminal judgements and civil court decisions, but is since 1995 also affirmed in legislation.⁶³ He directs that the duty to inform should be approached with regard to the specific patient, taking into consideration the patient's ability to understand, development, education and experience.⁶⁴

Closely related to the nature and scope of the duty to disclose are the surrounding circumstances and facts of each case that has to be taken into account to determine to what extent the patient must be informed.⁶⁵

⁶⁰ Van Oosten, F.F.W. 1996. Patient Rights: A status report on the Republic of South Africa. **Law in Motion - International Encyclopaedia of Laws - World Law Conference, 997**: "In the medical context this has been taken to mean that there will usually be a duty incumbent upon a doctor, as an expert, to furnish the patient, as a layperson, with the necessary and sufficient information to establish the requisite knowledge and appreciation and, hence, effective consent to the proposed medical intervention." He refers to the following authorities: **Esterhuizen v Administrator Transvaal** 1957 (3) SA 710 (T); **Stoffberg v Elliott** 1923 CPD 148; **Lampert v Hefer** 1955 (2) SA 507 (A); **Lymbery v Jefferies** 1925 A 236; **Richter v Estate Hamman** 1976 (3) SA 226 (C); **Castell v De Greef** 1994 (4) SA 408 (C); **S v Edouard v Administrator, Natal** 1989 (2) SA 368 (D); **Verhoef v Meyer** (Transvaal Provincial Division, 12 September 1975); **Mtetwa v Administrator Natal** 1989 (3) SA 600 (D); **Binta** 1993 (2) SACR 553 (C), **S v Kiti** 1994 (1) SACR 14 (E); **Administrator, Natal v Edouard** 1990 (3) SA 581 (A).

⁶¹ Van Oosten, 1995 *op cit* p 167, also **Pringle v Administrator Transvaal** 1990 (2) SA 379 (W), **Castell v De Greef** 1994 (4) SA 408 (C).

⁶² *op cit* p 202.

⁶³ art 7:448 BW - see *fn supra*.

⁶⁴ see *supra*.

⁶⁵ Van Oosten *op cit* p 171, appropriately lists various relevant considerations:

- the nature of the patient's disease or medical request;
- the nature of the proposed intervention;
- the available alternatives to the proposed intervention;
- the urgency and gravity of the proposed intervention;
- the potential adverse consequences of the proposed intervention;
- the degree of risk or danger that the proposed intervention entails;
- the frequency of complications;
- the expertise and experience of the doctor concerned;
- the professional personnel, technical resources, standard of hygiene and

An important aspect that should be remembered when a patient is informed is the fact that he is a layperson that could easily be intimidated by the use of medical jargon or a highly technical discussion or an un-sympathetical approach by the doctor. For this reason, physician must assess each particular patient to determine the correct scope and detail of disclosure. Beer states:⁶⁶

“Een gevoel van machteloosheid ten opzichte van de ziekte en van intimidatie door de medische terminologie en technologie plaatsen de patiënt meestal in een afhankelijkheidspositie van de arts.”

Although the duty to inform is a general duty with a broad application, it would appear⁶⁷ that no duty to disclose exists where the patient is already in possession of the required information;⁶⁸ the patient expressly or impliedly waives his right to information;⁶⁹ the so-called defence of ‘therapeutic privilege’ is applicable; or where disclosure in the circumstances is impossible.⁷⁰

5. Therapeutic privilege

This excuse to not informing a patient is found where the harm caused by the disclosure would be greater than the harm caused by non-disclosure. Here a physician makes a decision based on his own subjective opinion that the revelation of certain shocking/ disturbing information relating to the patient's health would cause the patient more harm than keeping this information from him, for example were an elderly patient without any prognosis of recovery would suffer great trauma when learning that he suffers from a dangerous disease, whilst he will in any event live for but a few months.

Leenen⁷¹ discusses a possible problematic situation that could arise from genetic diagnosis that could lead to the application of the so-called therapeutic privilege. This would occur where the

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- degree of specialisation of the hospital or clinic; and the patient's personal and professional circumstances.

⁶⁶ *op cit* p 54.

⁶⁷ Van Oosten, F.F.W. 1991. The Legal Liability of Doctors and Hospitals for Medical Malpractice. *SAMJ* (80), 25.

⁶⁸ *eg* where a patient has received the required information at an earlier consultation.

⁶⁹ see ch 2 and *infra* for a discussion on the waiver of rights.

⁷⁰ *eg* where the patient is unconscious.

⁷¹ *op cit* p 73, 164.

physician or genetic counsellor learns that the client suffers from of a serious, untreatable and previously undetected hereditary disease. A similarly difficult situation could arise where traces of genetic anomaly is detected which could possibly have affected already born children or probably will affect future children. Leenen writes that where knowledge of such devastating and unexpected news would cause the client serious damage, the genetic counsellor would be in a position to apply his therapeutic privilege.

Hondius⁷² agrees that the duty to inform could be suspended in cases where the individual entitled to the information would suffer serious harm as a result.

"Informatie hoeft niet worden verstrekt indien de patiënt hier ernstig nadeel van zou ondervinden. Deze zgn. therapeutische exceptie moet met terughoudendheid worden gehanteerd."

Grubb⁷³ writes that with regard to contraceptive advice, there should generally be no reason for withholding any information based on therapeutic privilege. This could, however, be possible where an operation is carried out on a woman with a diseased womb or if there were other pregnancy related-dangers the particular patient. He writes:

"It would seem that withholding information can only be justified by the doctor on the ground that he fears that knowledge of the small risk of reversal would deter the patient from having the operation. This ought not be a good reason for non-disclosure: it is paternalism at its highest..."⁷⁴

Strauss⁷⁵ also discusses the extent to which a patient should be informed of uncertain potential hazards. He believes that there is no duty to inform a patient of remote possible consequences and that a particular risk should be assessed based on empirical, statistical knowledge. It is submitted⁷⁶ that South African courts⁷⁷ would most likely leave the duty to inform to sound medical judgement and restrict disclosure of possible risks to those made by reasonable

⁷² *op cit* p 1697.

⁷³ 1988. Contraceptive advice and doctors - A law unto themselves? *The Cambridge Law Journal*, 12.

⁷⁴ *op cit* p 14.

⁷⁵ *op cit* p 9.

⁷⁶ *ibid.*

⁷⁷ *Richter v Estate Hamman* 1976 (3) SA 226 (C) at 232 H.

medical practitioners in similar circumstances.⁷⁸ There would therefore be no duty to inform if a physician is convinced that full awareness of the severity of a patient's condition would be therapeutically detrimental. A "common-sense" view is taken by the South African courts in this regard.⁷⁹

6. Right to information

Leenen⁸⁰ confirms the patient's right to proper information and concomitant principle that no valid consent⁸¹ can be given without sufficient information.⁸² He reports that the development of patients' right to information has influenced the patient-physician relationship in that some physicians consider this to be a breach of the traditional trust patients had in the physician's knowledge and discretion. Leenen⁸³ disagrees with this contention and believes that better communication between physician and patient will rather enhance the trust between the parties. He further states that proper communication will necessarily lead to more accurate diagnosis⁸⁴ and has the additional advantage of resulting in fewer complaints and negligence claims instituted by unhappy patients against their physicians.⁸⁵

Grubb⁸⁶ agrees that the quality of medical service would increase with improved disclosure and communication:

⁷⁸ see ch 4 on medical negligence for the "reasonable doctor test".

⁷⁹ **South Africa Medical and Dental Council v McLoughlin** 1948 (2) South Africa 355 (A).

⁸⁰ *op cit* p 170 - "*Niet informeren is niet nakomen van de overeenkomst. Indien daaruit schade is ontstaan, zal de patiënt daarvoor vergoeding kunnen claimen.*" i.e. failure to inform constitutes breach of contract on ground of which the patient can claim for any resultant damages.

⁸¹ it is mentioned that a patient can also at any time revoke his consent, upon which event the physician must discontinue the medical treatment, but only after informing the patient of the consequences of his revocation.

⁸² i.e. "informed consent".

⁸³ *op cit* p 164.

⁸⁴ it is reported that incorrect diagnosis leads to a considerable percentage of medical negligence claims.

⁸⁵ he refers to a study done in the U.S.A. where it was shown that well informed patients are less likely to blame their physicians for thwarted expectations.

⁸⁶ 1988. *op cit* p 14.

"If the medical profession were to volunteer more information, a franker dialogue between doctor and patient would result. This should also be the aim of legal rule-making in this context. Indeed, this would have the desired effect anyway, because there would be nothing for a patient to litigate about if he had been put in a position to make an 'informed' choice."

With regard to nature and scope of the physician's duty to inform, Leenen⁸⁷ states that a reasonableness criteria should be used. Under such a paradigm should be understood the release of information concerning facts and possibilities that a reasonable person would regard as necessary, under the circumstances, in order to reach a decision on a specific medical intervention, treatment and also its consequences. He writes that the importance or severity of a proposed medical intervention does not influence the scope of required information and rejects the notion that a lighter duty to inform is expected for trivial medical procedures.

Beer⁸⁸ writes that if every possible risk were to be disclosed, consultations would take an unacceptable period of time and patients will probably be unnecessarily unsettled as most complications occur very rarely. As illustration he questions whether it could reasonably be expected from an internist to disclose a 1 in 20 000 chance of complication in a particular treatment:

"Een ieder zal zeggen dat een juiste balans in de informatie moet worden nagestreefd, doch waar licht deze balans? Is de balans zoals hierboven⁸⁹ reeds kort aangeduid, althans in de optiek van de patiënt niet in belangrijke mate afhankelijk van de uitkomst van de behandeling?"⁹⁰

Earle⁹¹ believes that there is a difference between consenting to treatment and refusing it and that "it is doubtful whether the degree of disclosure of information required would be as high in cases where the patient refuses treatment on the basis of insufficient information and a risk associated with non-treatment eventuates; or that causation (in terms of remoteness of

⁸⁷ op cit p 165.

⁸⁸ op cit p 55.

⁸⁹ referring to the particular aspects that have to be discussed with the patient, as discussed *supra*.

⁹⁰ A paraphrased summary of this quotation is: Although it is clear that a balance must be found in the extent of disclosure necessary, it is not that simple to determine where that balance should lie. The entire discussion surrounding informed consent only becomes relevant once a patient is prejudiced and therefore the result of a medical intervention is maybe the most important factor to be considered.

⁹¹ op cit p 633.

damage) in such a case would be as easily proved.” He is further of the opinion that a patient should be nevertheless informed of the consequences of leaving the ailment untreated as well as any alternatives.⁹²

Schoonenberg⁹³ asks to what extent a physician could be expected to volunteer genetic information. He states in this regard that only vitally important information should be given out.⁹⁴

Leenen⁹⁵ reports on instances where the right to information is influenced by factors beyond the reach of the patient:

“Ook kan niet-informeren voortvloeien uit een conflict van plichten van de arts. Een voorbeeld is dat de arts over voor de patiënt belangrijke informatie beschickt, verkregen van familieleden die geen toestemming gegeven de patiënt in te lichten. Dat kan zich bijvoorbeeld bij genetische gegevens voordoen.”⁹⁶

A physician is as a general rule not entitled to inform the family of the patient concerning medical information of the patient because of his basic duty to secrecy.⁹⁷ He may only release information with the consent of the patient. There could nevertheless arise circumstances of necessity where a physician would have no choice but to inform others of important information relevant to them, which would necessarily result in a conflict of duties for the physician. As this would only happen in exceptional cases, Leenen reports,⁹⁸ there are barely any established rules governing such situations.

Strauss⁹⁹ reports with regard to a physician's therapeutic duty to inform the patient where

⁹² and their respective risks.

⁹³ Gevers, J.M.K. and Leenen, H.J.J. 1986. *Rechtsvragen rond voortplanting en erfelijkheid* Kluwer - Serie Gezondheidsrecht no.19, 62.

⁹⁴ “..uit eigen beweging die informatie te verschaffen die voor de patiënt van vitaal belang is.” *ibid.*

⁹⁵ *op cit* p 168.

⁹⁶ (168) *ibid* - a paraphrased summary of this quotation is: A physician's restraint to inform a patient could occur in the event of a conflict of interests, eg where he has received information relevant to the patient in question from a source who has not consented to the release of the information, possible in the event of genetic data.

⁹⁷ see *infra*.

⁹⁸ *op cit* p 170.

⁹⁹ *op cit* p 8.

failure to do so may cause him physical or mental harm¹⁰⁰ that the standard in America is rather that of the reasonable/ prudent patient, than that of the reasonable physician.¹⁰¹

Barrett¹⁰² has the following to say about the physician's duty to inform:

"The adequacy of disclosure is determined using the "prudent patient" standard: the physician must disclose all information which would be material to a prudent patient regarding the choices of proposed treatments and their inherent or potential risks."

In the South African case of **Richter v Estate Hamman**¹⁰³ it was found that a physician is negligent in failing to provide information to a patient if the reasonable physician would have done so under the same circumstances.¹⁰⁴ *In casu* it was testified by neuro-surgeon with regard to the reasonableness of a physician to withhold information, that different approaches are taken in respect of different complaints: If a patient's complaint is serious, the doctor should tend to emphasise the possible relief and minimise the risks, whereas a trivial complaint would call for the opposite approach.¹⁰⁵ Although this is an apparent view of some practising physicians, it is submitted that the subjective views of the physician¹⁰⁶ should not influence his approach towards the patient in respect of information. The court summarised the position in this way:

"If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation when the doctor knows full well that it would be in the patient's interest to have it. It may well be that in certain circumstances a doctor is negligent if he fails to warn a patient, and, if that is so, it seems to me in principle that his conduct should be tested by the standard of the reasonable doctor faced with the particular problem. In reaching a conclusion a Court should be guided by medical opinion as to what a reasonable doctor, having regard to all the circumstances of the particular case, should or should not do. The Court must, of course, make up its own mind, but it will

¹⁰⁰ therapeutic privilege.

¹⁰¹ **Canterbury v Spence** 464 F. 2d 772 (1972).

¹⁰² 1994. *Hummel v. Reiss*: The New Jersey Supreme Court Takes a Step Backward in its Recognition of Wrongful Life. **Rutgers Law Review** (46:465), 558.

¹⁰³ 1976 (3) SA 226 (C).

¹⁰⁴ see ch 4 on medical negligence.

¹⁰⁵ *ie* "the doctor should be perfectly frank and possibly even over-emphasise the risks" - Strauss *op cit* p 267.

¹⁰⁶ whether a specific ailment/ condition is serious or not.

be assisted in doing so by medical evidence."¹⁰⁷

6.1 A right to information or a duty to receive it?

Kamm¹⁰⁸ writes that the right to give an informed consent is really the right to have full information about the procedure on the basis of that information, which right can be waived, unless it is also a duty to be fully informed before one acts. She asks:

"Perhaps in medical context we have come to the point where we will not allow people to act without being informed and so will not allow them to waive their right to give informed consent. Thoughtful and informed decision making would then be not just a right but a duty."¹⁰⁹

An interesting viewpoint on the right to information is touched by Shepherd.¹¹⁰ He argues that although parents essentially have a right to receive information, societal attitudes will increasingly pressure parents into obtaining genetic information before childbirth, which will eventually place a duty on them to undergo genetic tests:

"Even absent legal recognition of such a claim against the mother, prospective parents face growing medical, economic and moral pressure to avoid the births of such children, primarily because of the extent of suffering that birth will entail. Prospective parents may feel an ethical or moral duty not to continue such pregnancies, to follow the medically indicated and prescribed solution rather than rely upon their own autonomous ethical and moral capacities. The emerging notion that a child has a right to be born healthy - a right essentially based in suffering - requires parents to adopt a medical response to predicted suffering which excludes other equally caring responses."¹¹¹

6.2 Standards of disclosure

¹⁰⁷ *op cit* 232 H.

¹⁰⁸ 1992. *Creation and Abortion - A study in Moral and Legal Philosophy* (Oxford University Press), 14.

¹⁰⁹ *op cit* p 187.

¹¹⁰ 1996. *Sophie's choices: Medical and Legal responses to suffering*. *Notre Dame Law Review* (72:1), 103.

¹¹¹ *op cit* p 108.

Earle¹¹² distinguishes between three possible standards from which the duty to disclose can be perceived, depending on whose interests are represented. The first is the medical-professional standard,¹¹³ the subjective-patient standard¹¹⁴ and the objective test standard.¹¹⁵ Earle is in favour of the objective standard in terms of which a physician would be expected to know that the seriousness of inherent consequences is directly proportional to the patient's desire for information. If a physician therefore knows that a particular patient has a special interest in possible risks or consequences of treatment, even very remote possibilities should be disclosed.¹¹⁶

Gevers¹¹⁷ conveys with regard to the standard of genetic examination and advice that:

*"Erfelijkheidsonderzoek en -advies dienen, zoals alle medisch handelen, te beantwoorden aan de professionele standaard. Dit begrip kan worden gebruikt als aanduiding van het geheel van beroepspligten waaraan het medisch handelen onderworpen is...drie bronnen worden onderscheiden waaruit dergelijke normen voortvloeien: de aard van het medisch handelen, de rechten van de patient en de maatschappelijke functie van de gezondheidszorg."*¹¹⁸

In conclusion as to whether a subjective or an objective standard of disclosure should be followed, one could say that the basic question is between the test of the reasonable physician or the prudent patient.

¹¹² *op cit* p 637.

¹¹³ as accepted by the English courts - see *infra*.

¹¹⁴ "According to which each specific patient would have to attest to whether he or she would have made a certain decision given the disclosure of risks, has been criticized for being prone to hindsight and to the whims of the unreasonable patient, and because it would not be practically possible to handle all patients identically and with a view to fairness under a subjective test." *op cit* p 637.

¹¹⁵ "The objective test is more practically operable. It disposes of the problem of hindsight by asking how the average prudent person in the plaintiff's situation would have decided, given the circumstances. It also dispenses with the problem of holding a practitioner liable for the whimsical courses of action of his or her patients under the subjective test." *op cit* p 637.

¹¹⁶ that would otherwise not be necessary.

¹¹⁷ *op cit* p 9.

¹¹⁸ A paraphrased summary of this quotation is:
Genetic testing, as well as the provision of genetic advice and counselling should adhere to the professional standard set for all medical practice, ie an indication of professional duties that regulate all medical conduct. Three sources can be identified from which these norms flow: the nature of the medical intervention, the rights of the patient as well as the social function of medical care.

7. Effective consent

It is important to note that while consent could usually be implied¹¹⁹ by a patient's conduct,¹²⁰ many difficulties can be avoided by granting express consent either orally¹²¹ or in writing. Van Oosten¹²² summarises the basic requirements of effective consent in a medical context:

- it must be recognized by law;¹²³
- consent must be given by someone who is legally capable of consenting;¹²⁴
- it must be informed consent;¹²⁵

¹¹⁹ Hondius *op cit* p 1699 states that the Dutch Civil Code (*Burgerlijk Wetboek*) pertinently recognizes implied consent to medical intervention in sec 7:466, on condition that the procedure is not serious or significant.

¹²⁰ After the physician's task is laid down (*ie* the medical problem has been discussed with the doctor), the patient generally gives his tacit consent to the doctor's inspection and treatment by allowing the doctor access to and assistance with the inspection of his/ her body. If the required medical intervention involves a more serious/ intensive procedure or an operation, a patient would most likely as a matter of general practice be expected to expressly consent to the intervention in writing. Physicians often feel safer to have "conclusive evidence" that a patient has in fact consented to a procedure - Van Oosten *op cit* p 24.

¹²¹ it is always difficult to prove the existence and precise terms of an oral agreement/ consent - see ch 2.

¹²² *ibid.*

¹²³ In accordance with public policy, as one may not under all circumstances consent to the infringement of rights. It would namely be legally impossible to consent to a definite, serious infliction of injury as this would be regarded as *contra bonos mores* (see *infra*). One will therefore have to determine in each particular instance whether the waiver of the right to information has in fact resulted in such an injury. If intended "consent" is given for a definite and serious injury, no legal permission for the infringement of a subjective right has been given and no waiver to institute action has in fact taken place. It is for this reason obvious that waiver of this right must not be taken lightly - see *infra* for a further discussions on the waiver of rights and the *pactum de non petendo in anticipando*. Neethling, J. Potgieter, J.M. and Visser, P.J. 1999. *Law of Delict*. Butterworths (3rd edition) 102: "The consent must be permitted by the legal order, in other words, the consent must not be *contra bonos mores*."
S v Collett 1978 (3) SA 206.

¹²⁴ As a general rule any sane and sober adult has the capacity to validly consent to medical interventions - note, however, that a married patient has to give consent to his/ her own diagnosis and treatment, also Neethling *et al*, *op cit* p 100: "A person is capable of volition when he has the mental capacity to distinguish between right and wrong and to act accordingly."

¹²⁵ legally adequate information is essential to enable sufficient knowledge and appreciation in order to give lawful consent - also Neethling *et al*, *op cit* p 100: "The consenting person must have *full knowledge* of the extent of the (possible) prejudice." **Castell v De Greef and Santam Insurance Co Ltd v Voster** 1973 (4) SA 764 (A) 781.

- it must be comprehensive;¹²⁶
- it must be clear and unequivocal; and
- it must be free and voluntary.¹²⁷

Further established principles regarding the legal requirements of lawful consent and voluntary assumption of the risk of injury in general are:

- the consenting party must fully realise/ appreciate the nature and extent of the harm;¹²⁸
- the person consenting must in fact subjectively consent to the infringement of his

¹²⁶ see p 2 *supra* - Berry *op cit* p 30 states that:
"In order to make the detail of the high technology tests available to those who usually have little technical knowledge it is important to communicate in a way that is appropriate so that the people concerned feel neither patronized by being talked down to nor overwhelmed by technical jargon."

¹²⁷ Neethling *et al*, *op cit* p 99, also *R v McCoy* 1953 (2) SA 4 (SR). Although one could perceive that the matter of individual consent to medical assistance would generally be without external pressure and interference, it could well be a different story in wrongful conception and wrongful birth cases as a child now enters the equation and therefore additional parties have interests in the diagnosis and all other medical interventions of the mother and (future) foetus. It could be that the father or prospective father may not agree with the mother's wishes to undergo/ not undergo an amniocentesis or other genetic testing procedure or even an abortion. In these instances the unfettered consent from the mother is of great importance, as her right to bodily integrity supercedes the father's interests in the unborn child - see § 12 *infra*, (for further reference to constitutional matters, see the discussion of the Constitution of South Africa, ch 9).

Freedom and security of the person

12. (2) Everyone has the right to bodily and psychological integrity, which includes the right -

- a) to make decisions concerning reproduction;
- b) to security in and control over their body; and
- c) not to be subjected to medical or scientific experiments without their informed consent.

Note also § 5 of the current abortion act on ch 3:

Consent

5. (1) Subject to the provisions of subsections (4) and (5), the termination of a pregnancy may only take place with the informed consent of the pregnant woman.

- (2) Notwithstanding any other law or the common law, but subject to the provisions of subsections (4) and (5), no consent other than that of the pregnant woman shall be required for the termination of a pregnancy.

¹²⁸ Neethling *et al*, *op cit* p 101: "Mere knowledge of the risk or harm concerned is therefore not sufficient; the plaintiff must also *comprehend* and *understand* the nature and extent of the harm or risk." - *Castell v De Greef, Waring and Gillow Ltd v Sherborne* 1904 TS 340.

rights;¹²⁹

- consent is a unilateral act which can be unilaterally revoked at any time before the actual infringement of rights takes place;¹³⁰
- consent is a legal act and should therefore be apparent and manifest;¹³¹
- consent may be given either expressly or tacitly;¹³²
- consent must be given *before* the prejudicial occurrence¹³³ and
- the infringement consented to must fall within the limit of the consent given.¹³⁴

Neethling *et al*¹³⁵ conveys that as consent is a ground of justification,¹³⁶¹³⁷ the person inflicting

¹²⁹ **Castell v De Greef, Santam Insurance Co Ltd v Voster**, 780. Van Oosten *op cit* p 173 writes that the focus must be on the patient who is capable of understanding the information and reaching a decision, while disclosure should otherwise only be to someone acting on the patient's behalf.

¹³⁰ Neethling *et al*, *op cit* p 98, **Jooste v National Media Ltd** 1994 (2) SA 634 (C), 649.

¹³¹ **R v Taylor** 1927 CPD 16.

¹³² express consent can be given either orally or in writing - see *infra* on written consent.

¹³³ as opposed to the *pactum de non petendo in anticipando*, where waiver of the right to claim can take place even after the infringement - the person consenting to harm intends to preclude the harmful act from being unlawful.

¹³⁴ **Burger v Administrateur, Kaap** 1990 (1) SA 483 (C), also the unreported case of **Verhoef v Meyer** (Transvaal Provincial Division, 12 September 1975), where a patient initially consented to treatment, but later was no longer willing to undergo an operation. It is vitally important that a physician obtains consent to a specific medical intervention and not only to treatment in general. Another important principle of consent is that it may be revoked at any time before the actual infringement takes place. Strauss *op cit* p 36 states that especially in cases of drastic or unusual surgery, a physician should set in writing the essential nature and risks involved and obtain written consent for such procedure.

¹³⁵ *op cit* p 104.

¹³⁶ *op cit* p 97, they mention that this justification is derived from the maxim *volenti non fit iniuria* (he who consents cannot be injured) found in the Roman and Roman-Dutch law *D* 47 10 1 5; *De Groot* 3 35 8 and *Voet* 47 10 4 and distinguish between two forms of consent: "Consent takes two forms: *consent to injury*, and *consent to* (or acceptance of) *the risk of injury*."

¹³⁷ Necessity and undue administration are other grounds of justification that can be raised by a physician against a complaint of physical infringement without consent: "Like unauthorised administration, necessity as a defence in the medical context also connotes lawful medical interventions in emergency situations, but unlike unauthorised administration it does not require that the patient was incapable of consenting or that the intervention must be against his will or that the intervention must be in his best interest." - van Oosten, 1991 *op cit* p 25. Van Oosten, F.F.W. 1996. Patient Rights: A status report on the Republic of South Africa. **Law in Motion - International Encyclopaedia of Laws - World Law Conference**, 992: "Moreover, in terms of a policy ruling of the South African

the injury or affecting the infringement of the consenting person's rights,¹³⁸ acts lawfully.¹³⁹ In this respect one should distinguish between prior consent and the so-called *pactum de non petendo in anticipando*.¹⁴⁰ Such an agreement is a contractual undertaking not to sue a wrongdoer¹⁴¹ who has in fact committed a delict.¹⁴² The agreement therefore identifies the individual in question against liability.

Earle¹⁴³ also conveys that legal consent has attached to it various facets of contract and quotes: "every human being of adult years and sound mind has a right to determine what shall be done with his own body".¹⁴⁴

Strauss¹⁴⁵, in summary, gives four "golden rules" relevant to obtaining consent:

- obtain consent from the person legally *competent* to give consent;
- obtain an *informed* consent;
- obtain a clear and *unequivocal* consent; and
- obtain a *comprehensive* consent.

8. Refusal to receive information

Medical and Dental Council (SAMDC) a medical practitioner is obliged, in cases of emergency, to render assistance at all times..".

¹³⁸ in medical terms a patient consents to the infringement of his personality rights and especially his rights concerning bodily integrity, as a physician is permitted to either examine, do tests, analyse, apply medication and on a more significant level, execute a medical procedure (eg give an injection/ x-rays) and even operate or amputate.

¹³⁹ Van Oosten, 1996. *op cit* p 999, reports on the landmark South African decision of **Castell v De Greef** in this regard: "The court prefers to place the doctor's duty of disclosure and its concomitant, the patient's informed consent, within the framework of the wrongfulness element rather than the fault element of delict."

¹⁴⁰ **Payne v Minister of Transport** 1995 (4) SA 153 (C) 160 and **Jameson's Minors v CSAR** 1908 TS 575.

¹⁴¹ *ie* a waiver of the right to institute legal proceedings.

¹⁴² and therefore has necessarily acted wrongfully - see ch 2 for a discussion on delictual liability.

¹⁴³ *op cit* p 630.

¹⁴⁴ **Schloendorff v Society of New York Hospitals** 211 N.Y. 125 N.E. 92 (1914), 97.

¹⁴⁵ *op cit* p 4.

Leenen¹⁴⁶ believes that an individual's right to refuse information has special relevance in the field of genetic counselling and declares:

"Bij erfelijkheidsadviesing heeft het recht om geen informatie te willen ontvangen, speciaal gewicht. Informatierecht is geen plicht om informatie te ontvangen. In het WGBO (art. 1653c) is het recht neergelegd om niet geïnformeerd te willen worden 'behoudens voor zover het belang dat de patiënt daarbij heeft niet opweegt tegen het nadeel dat daaruit voor hemzelf of anderen kan voortvloeien'. Bij erfelijk onderzoek met voorspellende mogelijkheden of waarbij ontdekking van een latente onbehandelbare ziekte tot de mogelijkheid behoort, behoren over het al dan niet informeren en de wijze waarop zal worden gehandeld, vóór het onderzoek afspraken te worden gemaakt. Dergelijke afspraken doen recht aan de zelfbeschikking van de patiënt. Ook na het onderzoek doch voordat de uitslag is medegedeeld, kan de adviesvrager nog besluiten niet te willen worden geïnformeerd."¹⁴⁷

9. Written consent

Although a patient can give his express consent to the fact that he has been properly informed by his physician either orally or in writing,¹⁴⁸ Legemaate¹⁴⁹ reports that a new trend is emerging to require written consent. This is probably an attempt by physicians to escape possible negligence liability based on failure to comprehensively inform their patients.¹⁵⁰

¹⁴⁶ op cit p 74.

¹⁴⁷ A paraphrased summary of this quotation is:
To have a right to information does not constitute a duty to receive information. The only instance where information could be "forced" on an individual is where the damage that he (or others) would suffer as a result of not knowing, is out of proportion to the forced receipt of information. Leenen suggests that client and counsellor should agree before genetic testing (with an inherently predictive nature) commences on the procedure that will be followed if a latent and incurable disease were to be detected. Such an agreement will supercede the patient's right to self-determination. A client/ patient could nevertheless still decide after the examination, but before the diagnosis has been made known, not to be informed about the results.

¹⁴⁸ **Stoffberg v Elliott** 1923 CPD 148.

¹⁴⁹ 1997. Het recht van de patiënt op informatie, mede in relatie tot de dossierplicht van de arts. **Advocatenblad** (77:5), 202.

¹⁵⁰ it is submitted that, although written consent should not be seen as a quick-fix solution to all problems related to the duty to inform and should certainly not be seen as a shortcut to a proper informative discussion, a written acknowledgement remains a valuable documentary evidence which will doubtlessly assist a physician in proving that the duty to inform was in fact adhered to.

Strauss¹⁵¹ explains:

"There are two different schools of thought on the best way to take consent. The one school holds that a detailed written consent should be taken; the other holds that there should be no written consent at all and that the doctor can rely on the patient's tacit consent. There is obviously no necessity to insist on a formal written consent in respect of minor procedures...The more drastic the procedure is, the more advisable it is in my opinion, from a legal point of view, for the doctor to take a fairly detailed written consent, in which the essential character of the operation is described in simple terms understandable by the layman."

Hondius¹⁵² reports that while both written and oral consent is statutorily recognized, oral consent is disadvantageous for the medical practitioner because of difficulties of proof. A drawback of written consent is that it would reduce the prevalence of oral consent. He suggests that a combination of both oral and written consent would be ideal.

Legemaate¹⁵³ warns of possible disadvantages that could result from the exclusive use of written consent. Firstly, he cautions against the replacement of the personal conversation-discussion between physician and patient with a standard type consent form. He mentions that it would be possible that patients are prejudiced hereby, in that they read through highly-technical jargon without understanding the meaning thereof and then consent to it without having the knowledge or appreciation. Secondly, he forewarns of a possible misconception that written consent by a patient will ensure foolproof protection against medical negligence liability.

He¹⁵⁴ reports on the official viewpoint of the KNMG¹⁵⁵ that there are more negative than positive attributes associated with written consent forms. Legemaate also reports on a further development in the Netherlands by the *Vereniging voor Obstetrie en Gynaecologie*¹⁵⁶ concerning policy regarding patient consent to sterilization. Although specific guidelines have been issued to physician assigned to perform sterilization procedures in the form of a checklist they have to refer to, no recommendation has been made to use consent-forms.

¹⁵¹ *op cit* p 289.

¹⁵² *op cit* p 1698.

¹⁵³ *op cit* p 207.

¹⁵⁴ Legemaate *op cit* p 206.

¹⁵⁵ "Koninklijke Nederlandsche Medische Gemeenschap", set out in 1995.

¹⁵⁶ the Dutch Obstetrics and Gynaecology Society.

Olsthoorn-Heim¹⁵⁷ explains that the Dutch “medical treatment agreement: expressly states that¹⁵⁸ orally obtained informed consent is sufficient and written consent would only be necessary in cases of drastic medical interventions or where the patient requests that all agreements be reduced to writing.

9.1 Written reports

Broekhuizen¹⁵⁹ reports on Leenen’s opinion with regard to the practice of comprehensively reporting every aspect of a patient’s condition and treatment in writing and states that it is unnecessary and impractical. He warns that a culture of defensive medicine might develop if written reports were to be required to provide an informed consent, which practice is concurrently detrimental to the physician-patient relationship:

“Daar ben ik op tegen, dat artsen alles gaan opschrijven en doemt zelfs het gevaar op van het Amerikaanse schriftelijke informed consent. Dit zijn onleesbare stukken. We hebben dit in Nederland nog niet. Gelukkig maar, want het is slecht voor de relatie tussen arts en patiënt en het leidt tot defensieve geneeskunde. Het recht zal daar iets aan moeten doen.”¹⁶⁰

10. Escaping liability

Fain¹⁶¹ reports that some doctors are attempting to protect themselves by telling every mother-to-be that she has at least a 2% risk of giving birth to a impaired child, as “standard procedure”. By doing this, the mother will be prevented from arguing afterwards that she wasn’t warned of the possibility of her bearing a defective child.

¹⁵⁷ 1994. Toestemming: de inhoud telt. *Tijdschrift voor Gezondheidsrecht* (3), 123.

¹⁵⁸ *“Op 22 Februarie 1994 aanvaarde de Tweede Kamer het voorstel van Wet geneeskundige behandelingsovereenkomst. De teneur is dat mondelinge toestemming volstaat. Volgens artikel 1653e is schriftelijke vastlegging - door de hulpverlener - alleen nodig voor ingrijpende verrichtingen en voor zover de patiënt om die vastlegging vraagt. Schriftelijke informatie kan ondersteunend zijn, maar niet vervangend.”*

¹⁵⁹ 1995. Rode draad: ‘Beroepsaansprakelijkheid’: Interview met prof. dr. H.J.J. Leenen. *Ars Aequi* (44:11), 851.

¹⁶⁰ *op cit* p 856.

¹⁶¹ 1987. Wrongful Life: Legal and Medical Aspects. *Kentucky Law Journal* (75), 585.

There is not implicit guarantee of success for medical interventions¹⁶² and the vast majority of physicians would not consent to or casually give such guarantee, as liability could then follow much easier. Gevers¹⁶³ writes that the correct transfer of information has become so important that it has become practice in some Dutch clinical genetic centra that those requesting genetic counselling receive a written report on the most important aspects concerning their condition/ the prospects discussed with them, which reports are, with the consent of the patient, sent through to the specialist/ general practitioner in question.

*"Naarmate de over te dragen informatie complexer is, zal de noodzaak toenemen om te waarborgen, dat geen misverstanden ontstaan."*¹⁶⁴

Lodeizen-Schoonenberg and Stein¹⁶⁵ writes on the validity of disclaimer clauses¹⁶⁶ and states that it could be *contra bonos mores* under certain circumstances.¹⁶⁷ They list various aspects that should be taken into consideration when establishing if it would be allowable, such as the level of fault in reference to the nature and seriousness of the consequences, the nature and content of the disclaimer agreement, the social situation of the patient as well as the nature of the relationship between physician and patient. Other relevant issues are the manner in which the parties reach consensus and the extent of appreciation the patient showed with regard to the gist of the waiver.

They¹⁶⁸ are of the opinion that exclusion of liability for sterilization procedures for failure to inform, would in general not be enforceable. Suggested reasons for this viewpoint are that the patient's decision to undergo a sterilization and the specific consequences thereof necessitate complete information regarding alternatives, unexpected repercussions and complications. It is the responsibility of the physician to instruct and advise a patient on the intervention and that

¹⁶² see ch 4.

¹⁶³ *op cit* p 11.

¹⁶⁴ *ibid* - as the information to be communicated becomes increasingly complex, the necessity to *guarantee the transfer of information*, to ensure that no misunderstandings result becomes more compelling.

¹⁶⁵ 1983. Uitsluiting van medische beroepsaansprakelijkheid. *Tijdschrift voor Gezondheidsrecht* (4:7), 167.

¹⁶⁶ "exoneratieclausules" - see *supra*.

¹⁶⁷ in terms of the Dutch Civil Code sec 2 (2), any general clause that is unreasonably prejudicial for a party to a contract, when taking into consideration the nature and content of the whole agreement as well as the reciprocal interests of both parties, is in principle voidable - *ibid*.

¹⁶⁸ *op cit* p 179.

it would be performed according to certain prescribed regulations, and attempts to bypass these duties by excluding liability would be unacceptable. However, it is argued¹⁶⁹ that a disclaimer would be perfectly in order where a patient has been properly informed.

“O.i. is er weinig bezwaar tegen aansprakelijkheid voor het feit, dat sterilisatie heeft plaatsgevonden alsmede voor de specifieke consequenties, die aan de ingreep verbonden zijn, tegenover de ter zake voldoende geïnformeerde patiënt uit te sluiten.”

Regarding waiver agreements, Leenen¹⁷⁰ conveys that is no supporter of this concept and states that these waivers are in any event not possible in terms of the Dutch “WGBO”¹⁷¹ or the Act on medical agreements. If a physician accepts the instruction to treat a patient, he must be prepared to accept the consequences.

“Ik ben daar geen voorstaander van. Volgens de WGBO is het ook niet mogelijk. De patiënt kan nooit overzien wat een dergelijke beperking of uitsluiting inhoudt. Als de arts zegt: ik doe deze ingreep alleen onder deze voorwaarden, dan heb je een onvrije situatie. Als de arts een medische behandeling uitvoert, dan moet hij voor de consequenties instaan.”

Strauss¹⁷² warns that, although written attested consent has “considerable evidential importance”, caution should be applied with regard to *pro forma* consent forms as these forms by themselves would be no defence to an action based upon assault if no explanation had in fact been given.¹⁷³

It is reported¹⁷⁴ that also hospital authorities¹⁷⁵ endeavour to exclude possible vicarious liability¹⁷⁶ by expecting patients to consent to imperious conditions of admission. Although it

¹⁶⁹ op cit p 180.

¹⁷⁰ as quoted in Broekhuizen 1995. *Ars Aequi* (44:11) op cit p 856.

¹⁷¹ *Wet op de Geneeskundige Behandelingsovereenkomst*.

¹⁷² op cit p 13.

¹⁷³ under these circumstances consent is only given in form, not in reality as decided in the English case of *Chatterton v Gerson* (1981) QB 432 at 443 D.

¹⁷⁴ Strauss op cit p 305.

¹⁷⁵ especially private hospitals.

¹⁷⁶ the fundamental principle concerning vicarious liability is that a person (or institution/ legal person) is not liable for the wrongful act of an independent contractor engaged by him, although circumstances may dictate that a legal duty is placed on an employer to take steps to prevent such harm to members of the

is mentioned¹⁷⁷ that several American jurisdictions have declared such waiver conditions invalid, it is submitted that South African courts will recognize unequivocal and properly defined exemptions, although intentional misconduct or grossly negligent conduct could not be legally endorsed by such agreement.

11. Diagnostic disclosure

Physicians are from time to time consulted for the specific and exclusive reason to give a professional opinion or diagnosis.¹⁷⁸ This would be the case in most wrongful life instances where an expert is asked to give his view on a specific matter, for example, the patient's chances of bearing a disabled child or transferring a hereditary disease. It is important that physicians appreciate the fact that these expert opinions are given on a professional-contractual basis and carry the same risk of possible liability should the physician be negligent in providing them. Because of the general duty on physicians to serve the best interest of their patients, it seems obvious that diagnosis disclosure would be imperative where it may affect the patient's decision whether or not to submit to the proposed intervention; it is an express or implied term of a so-called "diagnosis contract" between the doctor and patient; or where it is essential for therapy and a failure to do so may cause the patient physical and/ or mental harm.¹⁷⁹

Strauss¹⁸⁰ explains that the diagnosis concerns the question "Why?": in wrongful life terms, why should a specific patient undergo genetic testing or why is it potentially dangerous for a particular patient to have children (with his/ her spouse)? Strauss believes that a proper diagnosis is formed based on a complexity of symptoms, involving scientific assessment of each case on the basis of the physician's knowledge, skill and experience. He is not of the opinion that a general duty exists, to under all circumstances *fully* inform every patient of the diagnosis and submits that "full diagnosis must generally be given only where the patient

public.

¹⁷⁷ *ibid.*

¹⁷⁸ *ie* where a patient does not suffer from any ailment or expects the physician in question to provide medication.

¹⁷⁹ *eg* where a physician actually tries to convince a patient to undergo a specific test or medical procedure by emphasizing the medical importance/ benefits thereof, as would be the case where an elderly woman would be encouraged to undergo prenatal testing if she was found to be pregnant.

¹⁸⁰ *op cit* p 8.