

## THE CONSENT OF THE PATIENT TO SURGICAL AND MEDICAL PROCEDURES

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[Editors' Note.—After it had been delivered, Sir Norman O'Bryan revised that part of the paper appearing below which relates to infants. It is printed in the revised form. The discussion which is summarized was, of course, based on the paper as it was read.]

THE Common Law protects the ordinary man from the uninvited though well-intentioned and even perhaps beneficial administration of the medical practitioner. The Common Law does not give any right (nor does the Statute Law of this State, except in special cases such as a patient under the Mental Hygiene Acts) to legally qualified medical practitioners, so long as the patient is conscious and capable of making sane decisions, to interfere with a person's body without his consent, and *a fortiori* without his consent to remove a limb or an organ even without fee or reward and however desirable in fact such an operation may be.

That proposition is basic to the subject which I have to discuss this evening. The story is told of J. L. Purvis, the great Q.C. of the turn of this century, who, during one of his many cross-examinations of Dr. O'Hara, questioned O'Hara as to the fees he had charged for removing a small portion of a patient's tongue. Purvis was suggesting that O'Hara charged according to the pocket of his patient, and went on to ask what O'Hara would charge to remove a like portion of his, Purvis's, tongue. To which O'Hara replied: "In your case, Mr. Purvis, I would gladly remove the entire organ free of charge". No doubt there have been in the past, and there will be in the future, advocates the removal of whose vocal organ would be to the public benefit. However that may be, to perform that or any other operation upon a patient without his consent, the patient then being capable of giving or withholding such consent, will render the operator, and all knowingly concerned with him, liable to a civil claim for damages and to a criminal pro-

secution for assault, and there is no defence that the operation was for the public benefit or the private benefit of the patient.

The basic principle is expressed by the American lawyer, Mr. Justice Cardozo, thus: "Every human being has a right to determine what shall be done with his body and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages." All textbook writers of the Common Law who deal with this subject agree on this principle.<sup>1</sup>

The real difficulty arises in the case of patients who because of temporary unconsciousness or for some other reason such as infancy or lunacy are incapable of exercising a will or making a sane decision or giving a consent which the law will treat as binding. In such cases common sense calls for some juridical substitute for the consent of the patient.

Before leaving the adult patient who is fully conscious and capable of making a sane decision, there are one or two practical matters worthy of consideration.

First, a question may arise, in any particular case, whether consent has in fact been given. That, of course, is a matter of great practical importance to the doctor, and the surgeon may in the absence of writing or some corroborative evidence have to face a case in which it is the patient's word against his, whether consent was given to the actual treatment administered. Secondly, where there is no doubt that the patient did consent to an operation, a question may arise as to the extent of that consent, for example, was it confined to the removal or treatment of a particular organ, or did the consent expressly or impliedly extend to the doctor doing whatever might become necessary or appear to him to be necessary in the course of the operation? These are vitally important questions and they do arise in practice and the answer to them may, in many cases, determine the question of liability, but they are essentially questions of fact and fall outside the theoretical discussion as to what persons may give consent where consent by the patient cannot be had and whether consent by such a person is required in all cases, and whether it is sufficient in all cases, if given, and the still further question what juridical substitute, if any, has been devised for consent when consent cannot be obtained

<sup>1</sup> See for example *Taylor's Work on Medical Jurisprudence*, 10th edition, page 78, *Pollock on Torts*, 15th edition, page 113, *Halsbury*, 2nd edition, volume 33, page 33.

owing to the physical condition of the patient and the absence of anyone representing him.

An interesting illustration of the trouble a competent medical practitioner can get into who is not meticulously cautious as to consent before operative treatment is the well-known case of *Beatty v. Cullingworth* which was tried in the Court of Queen's Bench Division in London in 1896. Miss Beatty, who was a single woman engaged to be married, put herself under the care of Dr. Cullingworth, a surgeon. He performed the operation of a bilateral oophorectomy. Just before the operation, according to the evidence of Dr. Cullingworth, she told him that if both ovaries were found to be diseased he must remove neither, but that he replied "You must leave that to me". She denied having heard that remark. When she learned that both ovaries had been removed, she broke off her engagement and later sued Dr. Cullingworth for malpractice and assault. The jury brought in a verdict for the defendant. Mr. Valentine Ball in his article on Medicine and Pharmacy in volume 22 of *Halsbury's Laws of England* [2nd ed., p. 319] cites the case as authority for this proposition: "In the majority of cases there is doubtless an implied consent to do what the surgeon without negligence considers necessary or desirable. This consent would be negatived by express instructions not to do certain things; but if a surgeon found that it was necessary to do these things, and did them against instructions, it is difficult to see, apart from special circumstances, what damage the patient would have suffered." This is a more restrained statement of the law than appeared in the first edition under the same article (volume 20, pp. 332-3).

Taylor's *Medical Jurisprudence* cites *Beatty v. Cullingworth* as authority for this proposition: "If during an operation an unforeseen extension is seen to be inevitable, proof that such was in the opinion of the surgeon honestly necessary for the life or health of the patient would be sufficient to exonerate him."

Whether that proposition can be sustained in the entirety may be doubted, but I certainly do not think that the case of *Beatty v. Cullingworth* is authority for it. That action was tried before Mr. Justice Hawkins, and although the decision was upheld on appeal the legal discussion was inadequate, and the learned Judge's charge to the jury appears to have been little more than a direction or strong indication that a tacit consent to the operation had been given. In other words the verdict and

judgment appear to be based on the assumption that Miss Beatty did actually consent to the doctor doing in that case what he considered necessary after he had opened her up and while she would be under the anaesthetic. I may add that there was no evidence of negligence or malpractice, other than the allegation that the particular surgery was against instruction or at least not with express consent.

Is consent always and in all cases a complete answer for the legal responsibility of the surgeon? The answer, if we include in our considerations the Criminal Law, is "No". There are certain operations which, as is well known, are prohibited under pain of criminal responsibility, for example, criminal abortion. In that case the protected "person" is not so much the patient as the child which, if pregnancy were to proceed to a normal delivery, would be born. Also, of course, a person is not entitled to end his own life and no consent to operative or other treatment by a doctor designed to terminate or shorten life can justify the doctor's actions. Mercy killing is not yet part of the law of this country. I know of no case, and cases are not likely to arise, of a patient who for some reason engages a medical man unnecessarily to maim him, or remove a limb or organ. But if such a case did arise—and in our mad world can we be certain that anything is impossible?—the doctor would have no answer in a criminal prosecution for assault, nor probably even in a civil suit for damages, by pleading his patient's consent. Generally speaking, consent alone is not enough to justify what is on the face of it the doing of bodily harm to another. In the case of surgery there must be some kind of just cause, such as the cure or extirpation of disease. Wilful harm is no more excused by mere consent or assent, in the case of surgical treatment by a legally qualified medical practitioner, than is prize-fighting between a pair of thugs. (See Pollock *supra*, p. 113.)

Consent is not, therefore, in all cases an answer in a criminal prosecution of, or a civil action for, damages against the doctor for the performance of an operation on his patient. It is probably unnecessary to add that a doctor cannot recover a fee for the performance of an act which itself is a breach of the criminal law.

Other interesting questions can arise from the performance of such illegal operations. Suppose a patient consents to an operation for criminal abortion and it is performed negligently by the doctor, may she sue for resultant damage, or in the case

of her death, may her relatives sue for actual damages sustained by them by reason of her death? That and kindred problems have given rise to a diversity of judicial opinion in America. American decisions seem to favour the view that a person who consents to and participates in an illegal act cannot recover damages from the other participants for the consequences of them, though Pollock sees no such difficulty in an action for assault being sustained by one who has consented to an operation occasioning bodily harm which has not been performed for any curative or useful purpose. However, in many American States it has been held that damages cannot be recovered for negligence in the performance of such an operation, at all events when the patient was over 21 years of age and freely consented to the act. The courts which have so held have consistently followed this principle through by holding that if action by her would be barred had she survived, her relatives' right to recover is also barred, if she has died. American decisions are not all at one on this question, but this appears to be the prevailing view. But even under the view that a woman's consent to a criminal abortion precludes her recovery of damages for negligent treatment during such an operation, her consent must be real and voluntary and not induced by fraud or coercion or the like. In the cases in which it has been held that she, or her personal representative after her death, may recover damages, notwithstanding her consent thereto, the grounds for recovery have been predicated on various lines of reasoning. In more than one case it has been said that consent of the person injured by an unlawful act will not preclude recovery where the act involves a violation of the public peace or the life of the person is involved. In another case where the girl was under the age of 21, it was held that as a minor she could not legally consent to a transaction which constituted a criminal offence. A distinction has also been drawn between negligence in treatment, which on the better view is not actionable if the operation was itself illegal, and the abandonment of the woman by her medical practitioner after she has undergone a criminal abortion, the doctor well knowing that she is seriously ill as a result of the operation. It appears that such latter conduct would give rise to a cause of action notwithstanding the consent of the woman to the operation itself.

I leave now the consent of the conscious, sane adult patient and turn to consider the class of case upon which you have asked

me to address you and which therefore I presume is of more interest to you, *viz.*, that of the patient who either from lack of consciousness or because of age or mental weakness, is incapable of giving a consent. The very common case is that of a person who is injured and rendered unconscious in a street accident: what protection has a doctor if he, considering the amputation of a limb is necessary to save the patient's life or for the better preservation of his health, performs the operation of amputation? Suppose he does it without the consent of any relative or friend of the patient—either because there was no one available to give consent at the time, or because despite their refusal to consent he considers the operation necessary. Suppose he does get the consent of the patient's wife or husband or nearest relative; does the law provide who, if anyone, may stand in the patient's stead to give or refuse consent if the patient is unconscious? May the patient on recovery repudiate the consent given by his wife or other relative?

Suppose the doctor acts on his own opinion and against the refusal of a wife or husband or other relative to give consent. Does the law place anyone in the place of the unconscious patient validly to refuse consent to the operation?

Suppose afterwards medical opinion is that the operating doctor made an honest and reasonable (*i.e.*, non-negligent) mistake in taking off the leg, for example, and that the patient's leg could have been saved, is the doctor, in the absence of consent and he not having been negligent, liable as for an assault or trespass? Or has he an answer that in the reasonable exercise of skill he did what in the emergency he conceived to be the best for the patient? If the patient were an infant who was conscious, can he give an effectual consent so as to exonerate the doctor from responsibility for an operation performed pursuant to such consent, and can he effectually withhold his consent, so that if the doctor for his actual benefit performs the operation, the infant will have an action for damages for assault? Can the parent of an infant override the infant's consent or refusal as the case may be?

In the case of a lunatic, who, if anyone, can give or withhold consent to an operation considered to be necessary by his medical adviser?

I do not propose to answer each of these questions categorically. There are not many reported cases, particularly in the English and Australian courts, which give guidance on these

matters: You must keep in mind that we are not dealing here with any question of negligence; if there is negligence either in diagnosis or in the operation itself, the case is clearly actionable. If there is no negligence either in diagnosis or in operation, then the damage will in most cases be negligible and in most cases the patient will not become a litigant. But he may sue if he is advised later that the amputation, or whatever the operation may have been, was unnecessary and he did not consent to it. A friend of mine in the first war sustained an injury to his eye and the surgeon at the Base Hospital wanted to remove the eye. My friend objected and his objection was carried to a person who, I am told, is called the King's Surgeon. The King's Surgeon directed that the patient's refusal of consent should prevail, and my friend has two good eyes today. Nobody suggests that the army surgeon was malicious or negligent, but he turned out to be wrong. What if he had removed the eye without the soldier's consent? In a civil court he would have no answer to an action for assault however right his opinion was, and I know of no special rule of military law which subjects a soldier to the discipline of the army surgeon. The amount of his damages would depend upon the evidence the plaintiff could adduce to show that the eye could have been saved and the jury's acceptance of that evidence—but it would not have been a valid defence for the doctor to prove that he was not negligent in holding and acting upon the opposite opinion.

I have digressed in order to emphasize that what we are talking about here is simple absence of consent and not negligence, which may explain the paucity of judicial authority in this area of the law.

It might be convenient to deal first with a case for which the statute law of Victoria has made special provision, that is, a person who is a "patient" or a "mental treatment patient" within the meaning of the Mental Hygiene Act 1958. In relation to such a person the Chief Medical Officer of the Mental Hygiene Authority appointed under that Act is given authority by Section 212 to consent in writing under his hand to any surgical operation upon or any medical or other therapeutic treatment of any such patient by any member or members of the medical staff of any public hospital or mental hospital, and it is not necessary for the Chief Medical Officer to name in such written consent the person who is to give such treatment.

The statute requires the Chief Medical Officer before giving any such consent to satisfy himself that such operative treatment is necessary or desirable for the safety or welfare of the person proposed to be operated upon or treated. The statute also contains an emergency provision for the case where in the opinion of the Superintendent of any mental hospital the delay incurred in obtaining the consent of the Chief Medical Officer would endanger the life of any patient. In such a case the Superintendent may, by writing under his hand, give a like consent to doing those things to which the Chief Medical Officer may give his consent. If a Superintendent so acts he is required forthwith to report in writing to the Chief Medical Officer the circumstances under which such consent was given.

The effect of any such consent given under any of the foregoing provisions is that any medical practitioner who performs an operation or applies treatment, and any person concerned with the performance of such operation or the application of such treatment, has the same protection as if the consent had been given by the patient himself while he was of sound mind. Curiously enough the section goes on to say "and in the case of a minor, as if such consent had been given by his parents". I say curiously enough because this seems to give statutory recognition to the right of a parent to give or to withhold consent to surgical or medical treatment of a minor, as to which I will have something to say later.

The persons affected by these provisions are "patients" and "mental treatment patients" as defined by the Mental Hygiene Act. This includes a variety of persons. For example, it includes any person received into or detained in any mental hospital, hospital for the criminally insane, receiving house, receiving ward or private mental home. Each of these places has a special meaning in the Act but generally speaking they are houses or buildings or institutions licensed or proclaimed or constituted under the Act as such. It also includes all persons who are in any manner subject to be treated as insane or who are in any manner under any control or supervision as insane or persons of unsound mind, and until any of such persons are discharged under the Act, all persons who may have been under detention control or supervision or who may have been permitted to be absent on trial leave or parole under the Act or any corresponding previous enactment or who are boarded out or placed in a cottage established for the reception of paying patients or in a private mental

home. The word "patient", however, does not include persons detained in an institution under the Mental Deficiency Act of 1958 or allowed to be absent on trial leave or parole therefrom. These persons are subject to the special provisions of their own Act. A "mental treatment patient" is a person who comes under Part VI of the Act which relates to ex-soldiers, airmen and naval personnel suffering from mental disorders of recent origin, arising from, broadly speaking, war service, and who are boarded out under the provisions of that part of the Act.

It will be seen from the foregoing provisions that the person of unsound mind is pretty fully provided for by our Mental Hygiene Act. However, there can still arise in fact, unusual though it may be, the case of a person of enfeebled intellect who is not a patient or mental treatment patient within the provisions of that Act. If one had to consider for treatment the case of a person of enfeebled intellect who did not fall within the terms of the Statute, the first practical question would be the extent of his mental deficiency and the extent of control exercised over his person by any natural or *de facto* guardian. The first question in the case of such a person would be, is he capable of making a sane judgment on the matter in hand? If yea, his consent is necessary and sufficient. If nay, then if he has a natural or *de facto* guardian the consent of such guardian is necessary and sufficient. It would require a grave emergency to justify action where no consent is available or where such as is available is refused. In such a case his position in my opinion would be equated to that of the unconscious patient—which case I now turn to consider.

By the unconscious patient I mean one who is unconscious but who, if conscious, would be capable of giving a consent. As consent is the only justification for an operation if the patient is conscious and capable of giving consent, one naturally looks in the case of the unconscious patient for some juridical equivalent to or substitute for consent.

Unconsciousness, of course, may be induced by accident or other event outside the action of the doctor, or it may be induced by the use of anaesthetics in an operation consented to by the patient. Suppose in the course of such an operation the surgeon discovers a further condition of ill-health, call it B, beyond the patient's knowledge when he consented to be operated on for condition A. The surgeon is of the opinion that condition B necessitates the removal of another organ either to save the

patient's life or perhaps so that he may enjoy good health for the rest of his life. He has not got the patient's consent to remove that organ and the patient is now unconscious. Are the principles applicable to that case the same as those which apply to the patient carried to him, for example, unconscious in an ambulance fresh from the scene of a street accident? There is curiously little authority on these matters in our own courts. The case of *Beatty v. Cullingworth* to which I have already referred is an unsatisfactory one from the point of view of extracting any principle of law. It turned really on the issue of fact, "Did the patient leave herself in the hands of her surgeon to do what he considered necessary whatever emergency might arise in the operation?". In most operations an inference would be drawn that he did so act. But you can have the odd case in which the patient puts express restrictions upon his surgeon, and in such a case the surgeon would be well advised to consider seriously whether he should undertake an operation with such restrictions upon what he may thereafter consider to be his professional and moral duty.

There can, however, be no implication of real consent when the patient is unconscious when brought to the surgeon for the first time. Something other than real consent must be looked for to justify an operation. Where is it to be found? We get some guidance in this matter from the American courts. In the year 1912 in the State of New Jersey, U.S.A., one Bennan consented to be operated upon by a surgeon Parsonnet for a rupture to the left groin. After the patient was under the anaesthetic the surgeon found a rupture in the right groin dangerous to the patient's life. He operated on that side instead of the other. The patient brought an action for assault and battery. It was held that he could not recover. The case went on appeal and in dismissing the appeal the court used this language: "Without stopping to point out the fallaciousness of the premise that a surgical operation can be contracted for or performed according to plans and specifications, it is enough to say that the entire foundation of the supposed analogy is swept away by the surgical employment of anaesthesia which renders the patient unable to consent at the very time that the rule of the common law required that his consent be obtained.

". . . To meet this fundamental change in the condition of the patient it is imperative that the law shall in his interest raise up someone to act for him—in a word, to represent him in those

matters affecting his welfare concerning which he cannot act for himself because of a condition that has become an essential part of the operation. . . .

"The conclusion, therefore, to which we are led is that when a person has selected a surgeon to operate upon him and has appointed no other person to represent him during the period of unconsciousness that constitutes a part of such operation, the law will by implication constitute such surgeon the representative *pro hac vice* of his patient and will, within the scope to which such implication applies, cast upon him the responsibility of so acting in the interest of his patient that the latter shall receive the full benefit of that professional judgment and skill, to which he is legally entitled.

"Such implication affords no license to the surgeon to operate upon a patient against his will or by subterfuge, or to perform upon him any operation of a sort different from that to which he had consented, or that involved risks and results of a kind not contemplated. . . .

"If the surgeon transcends his implied authority as thus defined, the question of his skill and wisdom is irrelevant, since no amount of professional skill can justify the substitution of the will of the surgeon for that of the patient."

The Harvard Law Review (volume 26, 1912-1913, p. 91) contains this comment on the decision: "Ordinarily a surgeon is not justified in performing an operation more serious than the one expressly consented to. But when new conditions are found after the anaesthetic has been administered making a different operation advisable, the public interest in the preservation of life and health gives weight to the argument that the surgeon should be allowed to use his discretion. In such a case it has been suggested that the patient impliedly consents to the different operation. A result of this view is seen in the suggestion by the court in the principal case that there is consent to operations similar to that authorised and no more serious. It would seem better to rest the justification directly on grounds of public policy rather than on the fiction of implied consent. Such a justification would be confined strictly to cases where the patient's life was in imminent danger and in all other cases he should be allowed to regain consciousness and given an opportunity to give or withhold actual consent."

With respect I would state the position a little differently by saying that such justification should be confined strictly to

cases where the patient's life was in immediate danger or where, if the operation was not then and there performed, serious ill consequences to his health might result.

This line of reasoning finds support in a later case in Nova Scotia in Canada where the Chief Justice, after considering the above passage from *Bennan v. Parsonnet*, stated the principle in this way: "I think it better instead of resorting to a fiction to put consent altogether out of the case, when a great emergency which could not be anticipated arises, and to rule that it is the surgeon's duty to act in order to save the life or preserve the health of the patient and that in the honest execution of this duty he should not be exposed to legal liability. It is, I think, more in conformity with the facts and with reason to put a surgeon's justification in such cases on the higher ground of duty, as was done in the Quebec cases."

In an article in volume 11 of the Canadian Bar Review (1933) p. 506) Mr. Vincent McDonald points out that in American "Corpus Juris" it is said: "If in the course of an operation to which the patient consented, the physician discovers conditions not anticipated before the operation was commenced and which if not removed would endanger the life of the patient, he will although no express consent be obtained or given, be justified in extending the operation to remove or overcome them".

As was pointed out by Sir Charles Lowe J. in an article in *Res Judicatae*, volume 2, p. 179, to rest the right of a medical man to remove an organ without the consent of the patient upon a duty owed by the doctor, raises the question "to whom is the duty owed?". If to the patient, is the timorous surgeon who realizes the presence of the condition but refrains from extending the operation to be liable to his patient or his personal representatives if he dies, for breach of duty in not going ahead?

It is impossible to be dogmatic about the subject, but I am prepared to express my own conclusions thereon. First, I think the principle to be applied to the case of the unconscious patient is the same whether the unconsciousness is induced by an anaesthetic and a new and unforeseen emergency arises in the course of an operation to which the patient has consented, or whether the necessity to operate first arises when the patient is already unconscious. I am assuming in the former case that the patient has not given a general consent to do whatever may appear in the course of the operation to be necessary.

In either case it is fictitious, and to my mind absurd, to imply any consent where *ex hypothesi* no consent is possible. It may be objected that to say that you imply a consent merely means that you impute to him the consent which everybody knows does not really exist. But resort to such a fiction is not necessary, and in the ultimate development of the law may lead to limits being placed on the supposed consent which are as unreal as the consent itself and not in accordance with the requirements of the occasion. If you avoid the fiction and stick to realities it is more likely that the law will develop in accordance with common sense and actual requirements.

Where property is concerned the law has in many human and commercial relations developed the notion of agency of necessity. Well-known examples are the supply of goods to a deserted wife, and the power of the master of a vessel or a common carrier to jettison cargo. The law in many instances authorizes a person to act on behalf of another without that other's consent in circumstances of emergency, in order to prevent irreparable injury. In such cases the law generally requires (1) that the actor is not in a position to communicate with his principal, (2) that the course he took was necessary, in the sense that it was in the circumstances the only reasonable and prudent course to take, and (3) that he acted *bona fide* in the interests of the parties concerned. At the same time, though a strong case is required, it is not essential that any other course would have been an impossibility. Now it is by way of analogy to the law of property that I think the particular law relating to a surgeon's duty to the person of his unconscious patient should and will develop. And I would say that the principle should be and indeed is that if an emergency arises, whether it be in the course of an operation already undertaken or otherwise, and the surgeon is so placed that he cannot communicate with his patient and (1) a certain course is necessary in the sense that it is the only reasonable course to take (I mean by that that it is the only reasonable course to take for the preservation of the patient's life or to avoid a grave impairment of his health and comfort should he survive) and (2) the surgeon acts in good faith and without negligence and in the interests of his patient, then in my opinion the surgeon would be regarded in the law as protected by the necessity of the occasion from any action based upon absence of the patient's consent to the particular operation.

So far I have discussed the problem of the unconscious patient without any reference to consultation with any near relative such as a husband or a wife or a parent or an adult child of an elderly patient. In this respect an emergency arising during an operation may differ from the patient brought to a hospital or surgery in a state of unconsciousness induced by accident or otherwise.

It is conceivable in the former case that the patient may have expressly declared that the decisions as to further operative treatment beyond that already contemplated should be made by a particular relative or friend such as husband or wife or parent. If this is clearly the case the surgeon has no right to proceed contrary to such person's veto, or if the person deputed to give or withhold such consent is available, to act without his consent. This seems to be in accordance with the principle that the patient himself may refuse operative treatment however desirable or necessary it may be considered and there seems no reason why he may not depute another to act for him in this regard. The same principle of course would apply to the person picked up unconscious in a street accident, but it is unlikely that such a person would in advance have deputed anyone to give or withhold consent to operative or other treatment. It may be very nice and comforting and proper to inform relatives of the proposed treatment and even to do so under the guise of asking their consent. But in the end—except where the patient has himself appointed someone to act for him—the decision in the case of the unconscious patient is the medical man's responsibility. The consent of the husband, wife or parent will not help him, if he goes beyond the limits I have endeavoured to define, and if he keeps within them he will lose nothing by acting contrary to their wishes.

I come now to the position of the infant—a person is a minor and under most of the disabilities of infancy in our law until he reaches the age of 21 years, and it may be suggested that until he reaches his majority he is incapable of giving an effective consent to operations or medical treatment and that it is for his parents or guardians to give or withhold such consent, so that a consent given by them is sufficient and a refusal of such consent will override the wishes of the patient even if he be say of the age of 19 or even 20 years.

In support of this view is the theory of the common law that a parent's control over his children's education and up-

bringing continues throughout infancy. But while this is so, it has long since been decided that although the court will entertain an application by a parent for custody and control of a child who is still an infant, the court will not make an order for custody in opposition to the free and clear wishes of a child of the age of 16 years and upward. At that age the child is considered to be capable of making a sound and proper decision for himself. A child of that age who is out of a parent's custody and desires to remain out of it will not be compelled to return to it, at all events unless it is affirmatively established that his welfare requires it.

However, for the purpose of succession to property and the operation of wills containing dispositions conditional upon the donee being or remaining of a particular religion, it has been held that an infant cannot, until he attains the full age of 21 years, make a final decision as to what religion he shall adopt or practice. It was so held by Neville J. in a case of *re May Eggar v. May* 1917 2 Ch. 126.

From these considerations it has been suggested, as I have said, that an infant is incapable of giving consent to operative treatment, and that the medical practitioner must in all cases look to the parent or guardian for such consent, and that if he has the consent of the parent or guardian he may safely proceed regardless of the wishes of the infant. This proposition may also be said to be supported by statutory recognition in Sec. 212 of the Mental Hygiene Act 1958 where it speaks of a consent given pursuant to the provisions of that section in the case of *a minor* having "the same effect as if such consent had been given by his parents". Nevertheless in my opinion this is not the law. I say that for these reasons. In the first place at common law there is no actual legal obligation on a father or a mother to maintain a child unless the neglect to do so would bring the case within the criminal law. The criminal law is addressed to *any person* not necessarily a parent who is obliged by duty or contract to provide for an infant of tender years unable to provide for and take care of itself. If such a person neglects to provide sufficient food or bedding for an infant so as thereby to injure its health he is guilty of an offence punishable with imprisonment. The protection he it noted is in favour of infants of tender years unable to provide for or take care of themselves. The Children's Welfare Act 1958 Sec. 71 provides *inter alia* that every person who without reasonable excuse neglects to

provide adequate food, nursing, clothing, medical aid or lodging for any *child* in his or her care or custody shall be guilty of an offence. Under this part of the Act, *child* means a person under the age of 14 years, or when the School Leaving Act is raised under the Education Act 1958 to 15, a person under the age of 15 years.

An English decision reported under the name of *Oakey v. Jackson* 1914 1 K.B. 216 throws some light on the operation of this section. There a girl of 13 was suffering from adenoids and in consequence her health was being impaired. The only possible remedy was a surgical operation for the removal of her adenoids. The operation was not dangerous but her father, in whose custody she was, refused to allow his daughter to undergo it. He was summonsed under a section of the English Children's Act similar to our Section 71, and it was held that a parent's refusal to allow his child to undergo an operation might constitute a failure to provide adequate medical aid within the meaning of that section.

Secondly, in many actions for assault the consent of an infant will in many cases afford a good defence. Take the case of a young man of say 19 years of age playing league football who is heavily but fairly bumped and thereby injured in the course of a game. He sues his assailant for assault. The defence is that the injury was caused in the course of a lawful game in which the plaintiff consented to take part. Is it to be supposed that that defence would fail unless the parents of the infant had given their consent to his participation in the game? A like illustration might be given from a boxing match. Or say a girl of 20 goes to a hairdresser and has her beautiful locks removed and her hair reduced to modern style. She sues the hairdresser for assault. The defence is consent. Will that defence fail unless her parents have consented to the operation? But the medical man is in a like position. The action or prosecution against him will be for assault and his defence will be consent. There is something absurd in postulating of the emancipated infant, who though under 21 years of age may be married with a family of his own, to whose operations he is giving effective consents, that he cannot consent to his own medical treatment or may be denied medical treatment if his parents refuse their consent. The statute law impliedly recognizes that the consent of very young persons may be a defence to some criminal prosecutions for assault, by making special statutory exceptions to

the consent of very young children being a defence to prosecutions for certain sexual assaults.

Again, if analogy is sought from the law of contract or the law of property we find that though generally speaking a minor cannot make a valid and binding contract or make an effectual and final alienation by deed of real or personal property, there is an exception in the case of necessities which have been bought by the infant and are for the infant's benefit. In the law of marriage a minor, not being a widow or a widower, is forbidden to marry without the consent of its parent or guardian or some juridical substitute therefor as defined by the Marriage Act, but the absence of consent does not invalidate the marriage if the child is over the age of 16 years.

The law which limits the obligation of parents and custodians of infants to support and care for children under their care to that of infants of tender years, the law which provides that the consent of an infant in certain cases shall be a defence to an action or criminal prosecution for assault, the law in relation to the marriage of minors, and considerations of manifest convenience, all in my opinion negative the proposition that the emancipated infant cannot give a valid consent to operative or other medical treatment or that the consent of his parents or guardians is either necessary or sufficient.

An intermediate position has then been suggested, namely, that the consent of the parent or guardian is required while the infant is still under the tutelage or control of a parent or guardian but is no longer required after it has passed out of such tutelage or control and that thereafter the infant is capable of himself giving a binding consent. Under this theory it may be suggested that the parent when giving or withholding consent to medical treatment is exercising the right which the law gives him to correct, punish, restrain and generally to direct the life of his children under his tutelage. He is required, of course, to exercise these powers for the wellbeing of his children. When a doctor acts under such a consent it may be suggested that he is not acting with the consent of the infant in any real or even imputed sense, but that he is acting as the instrument of parental control conferred upon the parent by the common law. On that theory a doctor who operated upon an infant with the consent of his parents would in an action of assault by the infant have a defence not of consent or *volenti non fit injuria*, but that he acted as the instrument of lawful parental control.

In my opinion the objections which I have noted to the theory that an infant of whatever age is incapable of giving a binding consent to an operation or other medical treatment apply with almost equal force to the theory that an infant has a like incapacity so long as he remains under the tutelage or control of his parents or guardians with this added disadvantage that it would replace a certain test, *viz.*, the age of 21 years, for an extremely uncertain test. When does an infant cease to be under its parents' tutelage or control? Take a university student of 20 who still lives at home and is wholly supported by his parents. What would his position be if he received an injury in a football match such as I described above? Surely he has reached an age when he can choose for himself whether he will or will not play games in which he will subject himself to what would otherwise be assaults?

Whatever may be the correct legal analysis of the defence of the doctor who has, with its parents' consent, operated upon an infant of tender years, incapable of making a decision for itself, when you come to consider the case of children who can and do in many other matters make decisions for themselves and who in other actions for assault might have successfully raised against them the defence of *volenti non fit injuria*, you are forced back to the principle that any operation or medical treatment is an assault unless the medical practitioner has the patient's consent to what is done, and in the case of an infant, as in the case of any other person, the question is, has consent been given, and this is primarily a question of fact. In the case of an infant it includes the question: Is he capable of forming a sound and reasoned judgment on the matter to which he is asked to give his consent? The answer to that question may depend to some extent upon the nature and seriousness of the operation. In the case of very young children, and I would include in this children under the age of 14 years, I would think that a jury or a judge would in most cases of dangerous operations or amputations hold that such a person was not capable of forming a sufficiently sound or reasoned judgment on the matter to give any real consent to operative treatment. On the other hand, in the case of infants over the age of 17 years, I would think it highly probable that a jury or a judge would hold in most cases, when the patient was of normal intelligence for his years, that a free consent given by such a person was a real consent.

Between these ages the decision would probably depend upon the particular mental development and independence of the patient in question and the nature of the treatment or operation to which consent is sought. I think one can say no more than this. Between those ages the safe working rule may be to insist upon having the consent both of the patient and of his parents or guardians.

In the case of very young children who obviously are unable to make decisions for themselves—and as I have said I would think it is safe to include in that category children of both sexes under the age of 14 years—some other person has to make the decision for them.

I know of no authority on this subject, but as the basis of the right to operate in the case of an adult is consent, so in a case of a child who is in the custody and care of a parent or parents or guardians the person or persons who is or are in law responsible for his upbringing and entitled to direct his personal activities, such as where he shall live, how he shall be clothed and fed, his education, his religious upbringing and the like, is the natural person to look to for consent to medical treatment. And I think that must mean the person who has *de facto* control of his person for the time being. For example, if a child's parents were overseas and an elder brother or sister or aunt were in *de facto* charge of him, he or she would be the person to give consent. It should be noted that the guardian of an infant or a lunatic's property is not necessarily the one who has custody or control of his person. It is the guardian (natural or appointed) of his person that one looks to for consent to operative treatment.

In the case of such a person I consider that the consent of his parents or *de facto* guardians is necessary and sufficient for medical or surgical treatment of the infant. What if the parents disagree or, if there is more than one *de facto* guardian, they disagree—one urging or consenting to the operation and the other refusing consent or perhaps actively opposing the proposed treatment? If the matter is not one of urgency the wiser course would be to defer treatment. It may be in such a case that the parent or guardian could approach the court for guidance. If, however, the case were one of extreme urgency in which the life of the child were in jeopardy or if the failure to operate, in the opinion of the surgeon, would seriously affect the health and wellbeing of the child, he would be well advised to take

his courage in his hands and act upon the consent of the one parent or guardian and hope that the patient would be gracious and grateful and that, if not, a leading case would establish the doctor's right to act in the particular emergency. In like manner in a case of extreme urgency if there is no one present or available who has *de facto* control of the child, the surgeon himself in my opinion might be regarded as *pro hac vice* the *de facto* guardian; such as a child picked up in a street accident whose parents or relatives are unknown or unavailable in the time necessary for a decision to be made.

The most difficult question is probably the one in which both parents refuse to consent to an operation which the doctor considers necessary or desirable. The refusal may be based on religious or improper grounds. What is the doctor to do? Of course, if the operation is not urgent, proceedings might be taken against the parent under Section 71 of the Children's Welfare Act, but that would only result in the punishment of the parents. Proceedings might be taken to have the child made a ward of court and appropriate orders obtained. But what if the operation is of utmost urgency? I know of no right of the doctor to over-ride the parents' veto, or that "necessity" would be any defence to a prosecution for manslaughter if the child were to die as a result of the "assault". Whether the Crown would prosecute or a jury convict is another matter. The subject appears to be one which calls for consideration by the legislature, though statutory interferences with parental rights are to be closely watched and the grant of powers to the medical profession to interfere with the human body against the consent of the patient or those normally expected to act for him must be accompanied by appropriate safeguards. I say no more.

#### *Discussion*

SIR ALBERT COATES said that as a surgeon he had encountered the problem of the patient's consent, but had not always permitted the existence of the problem to have a restraining influence on him. Mercy killing had no place in our civilization. Pain could nowadays be controlled, and there was no reason why every human should not live as long as nature allowed him.

He had encountered the problem of consent during World War I, when ordered to perform knee cartilage operations on half a dozen soldiers regarded as malingerers. The soldiers did

not consent, and he had refused to operate, a refusal which had in the end been upheld by a higher headquarters.

In dealing with head injuries which had deprived the patient of reason, he thought that the surgeon's duty was to do what he thought best.

Investigational work presented a special problem. In this class of work hospitals were undertaking at times considerable risks. In a clinic in Minneapolis he had seen a number of major operations performed in circumstances where there was no indication that they would be curative, and he had seen a number of deaths result. In the case of this clinic, the patients who came to it knew the risks they were running. However, he himself did not understand how far the law permitted an individual to submit himself to dangerous procedures which were designed more to aid investigation than to aid the patient.

DR. CLIVE FITTS said that the doctor dealt with the situation with which he was confronted rather in accordance with the traditions which had been instilled into him during his training than on an appreciation of the legal consequences. He told of a case in which a young physician had been confronted at a private house with the necessity of performing a tracheotomy. As the kitchen carving knife turned out to be too blunt, a razor was procured. In fact the patient had made a recent attempt to perform a related operation upon his own throat with the same razor. The physician performed the operation with the razor and had the patient removed by ambulance to a hospital, where the only recognition of his feat was a comment by the junior resident who received him that the incision was too high. A few days later the doctor found the patient at his front door, but much to his relief the patient wanted only to inquire whether he had a claim for worker's compensation.

MR. R. A. SMITHERS, Q.C., said that the criterion of reasonableness was really the measure by which all the situations discussed must be judged.

He referred to two recent decisions, one by Lord Justice Denning and the other by Mr. Justice McNair, in which this had been stressed, in the one case in relation to a goitre operation which had impaired the patient's voice, and the other in relation to a convulsive treatment which had resulted in broken bones. The substance of the direction in both cases was that

the doctor was not liable if he had acted reasonably in relation to the patient's needs and to the state of medical knowledge.

MR. G. H. LUSH, Q.C., said that it was doubtful whether the consent to treatment given by the parent of an infant was a vicarious consent by the infant. If the parent and the surgeon conspired to commit an assault upon the infant, it was no defence to either of them that the parent consented. It was possibly a better view that the parent's part in the matter involved the exercise of his right of parental control. This right of control continues until the child is 21 years, and if it is a correct analysis to say that the consenting parent is exercising this right, some of the theoretical difficulties relating to children who have reached an age of understanding but not legal majority disappear. On this analysis, the surgeon takes a position analogous to that of a schoolmaster whose justification for inflicting corporal punishment is that he is exercising a delegated parental control.

MR. A. L. TURNER said that the speaker had not expressly referred to the kind of problem represented by the blood transfusion cases where all competent medical opinion was agreed that some action was necessary but parental consent was withheld. He would be troubled to think that in such a case the law prevented the carrying out of the necessary treatment. He agreed that in the case of an adult the patient must have the final authority—any different view would be an affront to human dignity. But in the case of a child, the last say should not rest with the parent.

PROFESSOR D. DYKSTRA, of the University of Utah, said that in most of the States of the United States a Children's Bureau with wide general authorities had been set up by legislation. The representatives of that Bureau would present problems arising in the treatment of infants to a court and obtain the directions of the court on the problem. Such situations required some delicacy of appreciation and handling.