# AGGRIEVED PATIENTS WHO CLAIM THEY WERE NOT TOLD: A NEW AVENUE OF REDRESS?

SUZIE LAUFER*

The scope of this article involves a brief examination of the existing legal avenues of redress for patients who claim they were not told of all that was involved in medical procedures performed on them. Little consideration is given to traditional common law actions, the focus being on a new and contrastingly simple legal action under the Western Australian Fair Trading Act 1987 ("FTA").

Having exposed a new and potentially threatening action against doctors in this increasingly litigious society the article then considers issues which underlie any legal action for redress and explores alternative avenues for reducing complaints against the medical profession.

Essentially the existing common law actions available to aggrieved patients comprise:

1. An action for breach of contract;
2. An action in trespass (or, as it is often referred to, assault); and
3. An action in negligence.

In an action for breach of contract, much of course, will depend upon the terms actually expressed or implied in the contract in each case. In this respect, an action based on breach of contract is a more limited means of redress for aggrieved patients.

* BJuris/LLB(UNSW) LLM(Hons)(Syd); Assistant Professor of Law, Director, Centre for Law & Medicine, Bond University.

An action in trespass is essentially confined to those cases where consent given was not free and voluntary, due to the incapacity of patients to give voluntary consent. Capacity may be impaired due to age, mental or physical disability. Furthermore, freely given consent maybe invalidated if the procedure performed goes beyond that for which consent has been given.

As a means of legal redress, it is quite clear, at least as a matter of common law in Australia, that so long as the patient is informed in broad general terms of the nature of the procedure and gives consent, there will be no action available in trespass.[1] Where the complaint relates to the sufficiency of the information provided concerning the risks or options involved in, or side effects of, any proposed procedure, the action will be based in negligence, which is far harder for a plaintiff to successfully establish.

An action in negligence in this context is based upon a failure of the medical practitioner to disclose relevant information. The success of such an action will depend upon a number of factors including whether there has been a breach of the duty owed by the medical practitioner to the patient. The answer to this question will depend upon just what information, in the court's opinion, is required to be disclosed by doctor to patient and the standard by which the medical practitioner is to be judged. In determining the extent of information a doctor should reveal to a patient, the court's concern is whether the doctor's conduct is reasonable in all the circumstances of the case. It is quite clear that the standard by which a doctor's conduct is to be judged is *not* merely by reference to general medical practice. If this were otherwise it would mean that the law would sanction what is essentially a paternalistic attitude on the part of the medical profession towards patients. Recent cases indicate that the law has moved away from this type of approach.[2] The problem is, however, that there are no precise formulations as to what is reasonable disclosure in any particular case. All that can be said is that the law will balance a number of factors against the basic principle that patients should make a decision only after having had the benefit of a certain amount of information. In determining how much information is necessary the kinds of factors the court will consider, include the patient's

1. *Chatterton v Gerson* [1981] QB 432; *Hills v Potter* [1983] 3 All ER 716.
2. *Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542, 562-563.

personality, understanding, and attitude; whether there have been specific requests for information; the actual procedure to be performed (the more drastic the consequences the more information should be provided); and the extent and likelihood of the possible risks and hazards involved.[3]

Further, once patients/plaintiffs have shown that there has been a failure on the part of the medical practitioner to disclose the requisite information, patients must still convince the court that they would never have consented to the procedure in the first place had they been fully informed.

It is this second aspect of the action in negligence that has caused most difficulties for plaintiffs, for in most cases the procedure in question was regarded as a last resort in what had generally been a long history of pain and complaint. It is here, however, that significant developments have recently occurred, with the decision of the New South Wales Court of Appeal in *Ellis v Wallsend District Hospital*[4] ("*Ellis*"). In *Ellis* it was accepted that this second hurdle for the plaintiff is to be judged by reference to a subjective test and will be satisfied by evidence indicating that the patient/plaintiff, and not the reasonable person, would have consented to the procedure if made fully aware and informed of the risks inherent in the proposed procedure.

In this type of situation there is the possibility of legal action being taken under the FTA. Similar legislation exists in all other states and territories except Tasmania.[5] The general purpose of the FTA, according to its preamble, is to make provision with respect to certain unfair or undesirable trade practices, in particular those relating to the supply of goods or services. In relation to the provision of medical services, the concern is with misleading representations made by medical practitioners as to the *quality* or *nature* of their professional services. The legislation allows a successful plaintiff to recover a monetary award similar to an award in an action in negligence. The purpose is to compensate the plaintiff for injuries sustained as a result of conduct which offends the legislation.

3. *F v R* (1984) 33 SASR 189; *Gover v State of South Australia and Perriam* (1986) 39 SASR 543.
4. (1989) 17 NSWLR 553.
5. See, for example, (NSW) Fair Trading Act 1987; (Qld) Fair Trading 1987; (SA) Fair Trading Act 1987; (Vic) Fair Trading Act 1985.

Actions under the FTA essentially mirror actions available under the Commonwealth Trade Practices Act 1974 ("TPA"). The TPA has not posed any real threat to medical practitioners. Why then is there concern about the FTA and its application to aggrieved patients who claim they were not told?

The reason for concern is that the FTA is not affected by the same rigid constitutional limitations which apply to the TPA. The TPA is restricted in that it can only apply to corporations due to constitutional limitations on the powers of the Federal Parliament. Such limitations do not exist in respect of the FTA. The result is that there is no reason why the terms of the FTA should not extend to individual medical practitioners whose conduct runs afoul of its provisions.

The FTA is concerned with the protection of the consumer. "Consumer" is defined in section 6. Any person "would be a consumer within the meaning of that term as defined in section 4 of [the Western Australian Consumer Affairs Act 1971]" and "who ... acquires ... services." Section 4 of the Consumer Affairs Act defines "consumer" as " a person who uses or is a potential user of, ... any service rendered for fee or reward." Although the FTA is breached in many cases, whether a consumer is involved or not, most of the civil remedies are available only where a consumer suffers loss. It is clear that a patient is a consumer as defined in section 6, and may be entitled to bring an action for damages under the FTA.

The main provisions of interest to a patient seeking monetary compensation are:

1. Section 10, which contains a general proscription against conduct, in trade or commerce, that is misleading or deceptive, or, likely to mislead or deceive; and
2. Section 12, which contains specific proscription of certain false or misleading statements, namely:
   (a) a false representation that services are of a particular standard or quality: sub-section (1)(b).
   (b) a representation that services have performance characteristics, uses or benefits they do not have: sub-section (1)(e); and
   (c) the making of a false or misleading representation concerning the need for any services: sub-section (1)(k).

The threshold question to consider under section 10 is whether a doctor can be said to be engaged in trade or commerce within the meaning of the FTA. The term "trade or commerce" is defined in section 5(1) of the FTA to include not only business but also professional activities. When one considers the nature and content of the professional activities of a doctor, especially when the services are provided for financial remuneration, there would appear to be little doubt that the provision of medical services is no different from the professional activities of the business community.[6] There is authority dealing with section 52(1) of the TPA which leads to the conclusion that a doctor giving professional advice about the need or nature of a suggested form of treatment would be engaging in conduct in the course of "trade or commerce" for the purposes of section 10 of the FTA.[7]

In the absence of some specific statutory limitation on the application of section 10, the giving of professional advice by a medical practitioner would amount to conduct for the purpose of an action based on contravention of this section. Indeed, the definition of "conduct" for the purpose of such an action is even broader. Section 5(4) of the FTA extends the definition of conduct to include refraining from doing any act, and so to a doctor who intentionally refrains from disclosing certain information to a patient because it is felt that this would create more harm and anxiety. In this way, silence may constitute "conduct" for the purposes of an action under the FTA. The practice of doctors vetting the information that is to be revealed to patients (the so-called "therapeutic privilege"), which creates problems at common law in determining the appropriate standard by which doctors are to be judged, is of no concern in an action under the FTA.

Once all of these threshold issues are established, it is then necessary to consider the gist of an action under section 10 of the FTA. The proscription is against the conduct that is "*misleading or deceptive or is likely to mislead or deceive.*"

6. D Everett and A A Ransom *The Fair Trading Acts* (Melbourne: Longman Cheshire, 1989) 398.
7. *Bond Corporation Pty Ltd v Theiss Contractors Pty Ltd* (1987) 14 FCR 215 French J, 220, where it was held that the giving of professional advice by a consulting engineer could constitute conduct in "trade or commerce".

The question is then: what amounts to conduct that is misleading or deceptive? Clearly these words are quite broad and it may be that one could argue that they should therefore be read down in some way. However, in cases dealing with the equivalent provision under the TPA the courts have not taken such a restrictive approach.

In *Weitmann v Katies Ltd,*[8] a case under section 52(1) of the TPA, the court resorted to a consideration of the general dictionary meaning of the terms "misleading" and "deceptive". It was noted that the word "deceive" was defined in the Oxford Dictionary as " to cause to believe what is false, to mislead as to a matter of fact ", and the word "mislead" was defined as "to lead astray in action or conduct, to lead into error, to cause to err".[9]

Support for a liberal approach to the interpretation and application of section 10 comes from the FTA itself. Conduct which offends section 10 may also amount to contravention of the more specific provisions in section 12 dealing with precise types of misrepresentation. In this way, section 10 operates as a catch-all provision and so has a potentially broad application. Using cases under the TPA as a guide, it would appear that the courts will be unlikely to adopt a restrictive approach to the application of the provisions of the FTA. This is further supported by the preamble to the FTA which affirms that the intention of the legislation is to protect consumers. There is no doubt enormous potential for aggrieved patients to claim that by not being fully informed, they were misled or deceived or were likely to be misled or deceived.

The principles developed in relation to the TPA are applicable in considering whether conduct falls within section 10 of the FTA.

First, it is necessary to identify the relevant audience to which the conduct is directed.[10] In medical negligence cases this will not usually be a problem as it is possible to identify an individual patient in each case who claims to have been misled.

Secondly, the more important question is to determine the standard by which the conduct is to be judged. It is here that significant differences exist in respect to a common law action in negligence. Under the FTA, having identified the relevant section of *the public* affected by the

8. (1977) 29 FLR 336.
9. Ibid, 343.
10. *Brown v Jam Factory Pty Ltd* (1981) 53 FLR 340, 349.

conduct, the question whether conduct was misleading or deceptive will be judged by reference to all who come within the scope of *the public*:

> Including the astute and the gullible, the intelligent and the not so intelligent, the well educated as well as the poorly educated, men and women of various ages pursuing a variety of vocations.[11]

In this way the standard is set by reference to that section of the public, the ordinary patient, which is exposed to the conduct.

Thirdly, the actual test of whether conduct is misleading or deceptive or is likely to be so is a purely objective question for the court in each case. Obviously, evidence that a particular individual has, in fact, been so misled or deceived will be persuasive.

The last element is causation. Before civil redress is available there must be some causal relationship between the misleading or deceptive conduct and the loss actually incurred by the plaintiff.[12] This is different to the causation issue in an action in negligence and would appear to present no problem in a medical negligence scenario as the only requirement is *factual* causal connection.

Perhaps the most significant difference between an action under section 10 of the FTA and an action in negligence is that a breach of section 10 does not involve any mental element on the part of the defendant. There does not have to be any intention to mislead or deceive. This has enormous consequences for doctors because it means that they may engage in conduct that is misleading or deceptive for the purposes of the FTA, even though they act honestly and reasonably.[13] A purely innocent mistake about the nature of the proposed treatment given to a patient may nevertheless be misleading or deceptive or likely to mislead or deceive and doctors will be liable under the Act to all those who suffer some loss as a result of that conduct. This factor alone gives the action based on a contravention of section 10 far greater scope than an action in negligence in the context of medical negligence litigation.

11. *Puxy Pty Ltd v Parkdale Custom Built Furniture Pty Ltd* (1980) 31 ALR 73 Lockhart J, 93. See also *Teco Company of Australia inc v Taco Bell Pty Ltd* (1982) 42 ALR 177 Franki J, 202.
12. See FTA s 77(2).
13. See *Yorke v Lucas* (1985) 158 CLR 661 Mason ACJ, Wilson, Deane and Dawson JJ, 666, a case on TPA s52.

Furthermore, it is of no concern that a statement made by a doctor is literally correct. So long as it has, or is likely to have, the effect of misleading or deceiving a patient, it will be contrary to section 10.[14]

Perhaps the only real limitation on the application of the FTA to a medical practitioner lies in relation to those circumstances where all that the doctor does is express an opinion, as opposed to a prediction, as to possible outcomes. So long as the statement is no more than that, and is constantly qualified as such, this will not of itself amount to misleading conduct for the purposes of section 10.[15] However, where some ambiguity exists as to the possible meaning to be attributed to a statement, the general standard that is applied to determining whether or not there has been a contravention of the section may result in the court deciding that there has in fact been a misrepresentation or other misleading conduct.

It should now be apparent that there is no precise formula for determining whether conduct contravenes section 10. This alone makes it a potentially threatening means of legal redress against the medical profession. In deciding whether there has been a breach, all the circumstances of the case need to be considered. The courts are concerned with the overall impression that may have been created and will not necessarily focus on particular words or statements. Rather, the general context of the conduct in question will be considered. In this way, for example, a mere failure to note a certain factor may colour the conduct in such a way as to make it misleading. In *Hospitals Contribution Fund of Australia Ltd v Switzerland Australia Health Fund Pty Limited*[16] an advertised claim by a health fund that it offered the best value health care was held to be misleading under section 52 of the TPA. This was because of the advertiser's failure to note that other funds merely provided for a reduction in the rate of benefit after a certain period of hospitalization and did not explain cost reduction practices of other funds in certain circumstances; nor did it note differences in the cover offered by the funds.

It is submitted the Court's approach in focussing on the overall impression created by conduct means that silence may itself constitute conduct that is misleading or deceptive. The issue of silence has been

14. *Hornsby Building Information Centre Proprietary Limited v Sydney Building Information Centre Limited* (1978) 140 CLR 216 Stephen J, 227.
15. See *Global Sportsman Pty Ltd v Mirror Newspapers Pty Ltd* (1984) 2 FCR 82, 88.
16. (1988) 10 ATPR 49-108.

considered in relation to section 52 of the TPA and the Full Federal Court has held "that silence may be relied on ... when the circumstances give rise to an obligation to disclose relevant facts".[17] Doctors who say nothing about proposed procedures may just as easily be creating a misleading impression. So long as the patient/plaintiff shows that silence on the part of the doctor created the mistaken impression in circumstances where there was an obligation to disclose relevant facts, an action would lie.

Even if it cannot be established that the conduct in question is misleading or deceptive, or likely to have that effect, for the purposes of an action under section 10 it is still possible that the conduct in question could contravene the more specific provisions of the FTA dealing with particular misrepresentations. For example, there would appear to be little problem demonstrating in appropriate cases that doctors had falsely represented that "services are of a particular standard, quality or grade" contrary to section 12(1)(b) of the FTA. Again, cases under the equivalent provision in the TPA show that "quality", for example, has been interpreted widely enough to include the virtues, attributes or special features of the service in question.[18] A doctor, therefore, who indicates to a patient that a suggested procedure will eliminate the patient's current pain would most likely run afoul of this provision if the procedure fails to do so. Equally, such conduct would contravene section 12(1)(e) in that it would amount to a representation that the doctors services have performance characteristics, uses or benefits which they do not have. The analogy is quite apparent when one considers, for example, the case of *Dillon v Chin*[19] where a commodity broker, whose employee induced a number of clients to invest by making various false assertions about the return to be achieved from an investment and the lack of risk involved was found to be in breach of section 53(c) of the TPA. The analogy with a doctor making certain assertions about the benefits to be gained from a proposed operation and the lack of risk is quite apparent.

17. *Henjo Investments Pty Ltd v Collins Marrickville Pty Ltd* (1988) 79 ALR 83 Lockhart J, 95. See also *Rhone-Poulen Agrochimie SA v UIM Chemical Services Pty Ltd* (1986) 12 FCR 477.
18. *Ducret v Chaudhary's Oriental Carpet Palace Pty Ltd* (1987) 16 FCR 562 Ryan J, 577.
19. (1988) 10 ATPR 49-670.

Finally, there is the potential for a doctor to contravene the specific provision of section 12(1)(k) of the FTA by making a false or misleading representation concerning the need for any services.

The only threshold question to the application of section 12 is to demonstrate that the provision of medical services comes within the definition of "services" in section 5 of the FTA. There appears to be no problem in showing that the provision of medical services constitutes the provision of "benefits, ... or facilities that are, or are to be, provided, ... or conferred under ... a contract for or in relation to ... the performance of work (including work of a professional nature)".

As for the remedies that are available in an action under the FTA, a patient suing a doctor would be able to claim damages for all loss suffered as a result of the offending conduct because a patient/plaintiff would constitute a consumer for the purposes of sections 6 and 79 of the FTA. In addition, there exists the possibility of additional awards by way of compensation under section 77 of the FTA. Whilst it is not settled how an action for compensation under section 77 lies with an action for damages under section 79, it is clear that a patient suing under the FTA would be in no worse a position vis-a-vis damages than if an action were brought at common law for negligence. Furthermore, the measure of damages for the purposes of an action under the FTA will be the same as the measure of damages in a common law action for negligence, especially where the action is under section 10 for misleading and deceptive conduct.[20] Indeed, there is some indication that the measure of damages in an action under the FTA is potentially wider than for a common law action for negligence.[21] The relevant question to be asked in each case is how much worse off the plaintiff is as a result of having relied on the deceptive or misleading conduct of the defendant?[22]

20. *Gates v The City Mutual Life Assurance Society Limited* (1986) 160 CLR 1, a case concerning s 52 of the TPA.

21. *Frith v Gold Coast Mineral Springs Pty Ltd* (1983) 65 FLR 213 Fitzgerald J, 232:

> [W]hilst common law rules as to the measure of damages in tort may, in appropriate circumstances, provide a useful guide, no justification exists for confining the damages which are recoverable under ss 82 and 87 by references to common law tests.

This case refers to the TPA.

22. Supra n 20, 12.

It is, therefore, apparent that there is no reason why aggrieved patients who claim they were not told could not bring an action for redress under either section 10 and/or section 12 of the FTA. Indeed, such an action could be brought to supplement the existing common law actions already available. The FTA expressly states that it is not intended to exclude or limit the concurrent operation of any law of the Commonwealth or of another State or a Territory.[23] Furthermore, as with most consumer protection legislation, there is an express provision preventing contracting out of the provisions of the FTA.[24] When the availability of similar remedies under the FTA is coupled with the relevant ease of establishing a cause of action, there appears to be no reason why the FTA should not prove to be the bane of doctors in the future.

Perhaps the application of these provisions can be best examined by comparison with decided cases in negligence at common law. Consider the facts of a case such as *Ellis*[25] or the more recent case involving the transmission of Acquired Immune Deficiency Syndrome ("AIDS") via blood product factors in *H v Royal Alexandria Hospital for Children*[26] ("*H*"), and see how such cases could have been run on the basis of an action under the FTA.

In both of these cases the legal avenue for redress used was an action in negligence. In *Ellis* the essence of the complaint was a failure on the part of the doctor and hospital to disclose the risks and side-effects of the proposed procedure. In *H* the complaint related to a failure on the part of the hospital to warn the plaintiff's parents of the possibility of infection from diseases transmitted in blood factor products in respect of treatment with a blood factor administered in the hospital. In both cases the plaintiff failed: in *Ellis* on the basis that the hospital was not to be held vicariously liable for the surgeon's negligence; and in *H* on the basis that the parents could not establish that had they been adequately told of the risk of infection they would never have consented to their son receiving the particular treatment. In addition, in *H*, a major part of the decision turned upon the timing of the infection. If treatment had been received at

23. FTA s 4(4).
24. FTA s 5(9).
25. Supra n 4.
26. (1990) Aust Torts Reports 67,503.

an earlier date it would not have involved any breach of duty on the part of the hospital because the state of knowledge about transmission of disease through blood products at the earlier date meant that it was not reasonable to expect the hospital to disclose the risk of infection. Both these hurdles could be circumvented by a patient by pursuing an action under the FTA.

To bring an action under the FTA in either of these factual situations, the patient would first of all have to determine the offending conduct. In *Ellis* the conduct in question could be classified as a misrepresentation by the doctor as to the nature of the procedure to be performed. The doctor gave Ellis the impression that the operation, a laminectomy and cervical posterior rhizotomy, would most probably eliminate the constant pain which she had suffered in her neck for four years. In other words, the doctor gave Ellis the impression that the operation had a very high success rate. This was not, in fact, correct. In so describing the nature of this operation, the doctor failed to indicate that there was any risk of developing paraplegia or quadraplegia. The impression created was that there would only be a risk of some slight numbness in her right hand. The trial judge, whose findings on these points were not challenged on appeal, concluded that the doctor had formed his own opinion as to the necessity or justification for performing this procedure. Ellis became a quadraplegic a few days after the operation was performed.[27]

The New South Wales Court of Appeal decided that the conduct of the doctor amounted to a misrepresentation.[28] Such a negligent misrepresentation would come within the terms of section 10.[29] Furthermore, there is every reason to believe that the conduct would also amount to a breach of section 12(1)(b), and even section 12(1)(e). The doctor could be seen to have represented that the services to be performed were of a particular quality, in that it had certain virtues, attributes or special features, namely, relieving Ellis' current pain. Likewise, the doctor could be said to have misrepresented to Ellis that the services to be provided had certain performance characteristics and benefits that they did not in

27. Supra n 4, 574-578.
28. Ibid, 579.
29. See, for example, *Adams v Classic Autocraft (Australia) Pty Ltd* (1985) 7 ATPR 46-944, where an inaccurate quotation was held to be a misleading statement grounding an action for damages under s 52 of the TPA.

fact have. They were not likely to relieve the pain without substantial risk or hazard.

As discussed above in an action under section 10 it would not have been necessary for Ellis to lead evidence as to what she would have done had she been correctly informed. This was a crucial point in the actual case where the cause of action was framed in negligence. In contrast, all that is required for an action under section 10 of the FTA is that there was conduct that is misleading or deceptive, or indeed merely likely to mislead or deceive and, in order to obtain damages, that a casual relationship existed between that conduct and the damage ultimately incurred. It is apparent that an action under section 10 of the FTA is, from an evidentiary point of view, a far simpler action for a plaintiff to bring.

The only other hurdle in *Ellis*, and indeed, the basis upon which Ellis ultimately failed, was that the hospital could not be held vicariously liable for the conduct of the doctor, and that the hospital did not owe Ellis any independent duty of care in this respect. The background to the case was that the doctor in question died prior to the case coming on for hearing and Ellis settled the claim against the executors of the doctor's estate before trial. The action therefore was limited to an action against the hospital, and thus it was necessary to show that the hospital was either vicariously liable for the doctor's conduct, or in breach of an independent duty of care. Again, this hurdle disappears if the action is brought under the FTA, because the FTA imposes liability upon principals for the conduct of others, but in a far broader sense than the notion of vicarious liability at common law. The legislation extends the web of liability and makes a corporation responsible for the conduct not only of its own directors, servants or agents, but also for the conduct of other persons who carry out work at the direction of, or with the consent or agreement of, a director, servant or agent of the corporation.[30] In other words, liability may be imposed on the hospital for the conduct of an honorary such as the doctor in *Ellis* even though the hospital may not have been vicariously liable at common law. The FTA deems the conduct of the other person to be also the conduct of the principal and so makes the principal directly liable. Taking the circumstances in *Ellis*, it would be

30. FTA s 82(4).

possible to argue that the doctor was acting either at the direction of the hospital via the medical superintendent pursuant to the hospital by-laws or, at the very least, with the agreement of the medical superintendent, such that the doctor's conduct would be deemed to be that of the hospital for the purposes of an action under section 10.

Finally, there would appear to be no problem in establishing the simple factual causal connection between the offending conduct and the resulting loss and damage incurred by Ellis.

In considering an action under the FTA in the same circumstances as existed in the case of *H*, it becomes even more apparent just how broad this cause of action is. As stated above, the problem in that case related to two points.

First, the problem of establishing that there had in fact been a breach of the duty owed by the hospital to the patient/patient's parents. This related to the state of knowledge about the possibility of cross infection via blood products, and hence the reasonableness of the conduct on the part of the defendant hospital. Of course, there is no such requirement of fault in an action under the FTA. It could, however, be argued that the conduct on the part of the hospital amounted to a false representation that the services it provided (the provision of treatment with a blood factor product) was of a particular standard, quality or grade and that there was an impression created that the blood factor administered to the child would be free of contamination and would not involve any risk of infection from diseases transmitted in blood.

The second problem related to the difficulty of proving that had the parents been properly informed of the potential risk of infection for their child, they would never have consented to the treatment. Reliance is not the only element of an action under either section 10 for misleading or deceptive conduct, or under section 12 for specific false representations, but it is a necessary element.

The foregoing raises the practical question: "What does a doctor do to ensure compliance with these provisions of the FTA?"

The answer to this question is made all the more difficult because there are no decided cases. One can only speculate as to how such an action may be dealt with by a court. It appears that the only real means of preventing a contravention of the FTA is for a doctor to ensure that it is made clear in all cases that all that is being offered to the patient is a professional opinion, given the existing facts of the case. So long as doctors constantly qualify their remarks as merely an expression of

opinion, and so long as they have no deliberate intention to mislead or deceive, there would appear to be no problem.

This answer does, however, raise what appears to be the underlying concern of the aggrieved patient in all these cases, whether the action is brought in negligence based on lack of informed consent, or under the FTA. What is really involved is concern about the communication processes, or lack thereof, in the doctor-patient relationship. At the very heart of such complaints lie consumers who are aggrieved by the communication processes involved in their treatment. Many complaints could be equated with a complaint about communication standards adopted by the medical profession itself. Doctor John Vallentine of the Medical Defence Union of New South Wales has stated that failures of communication form the basis of thirty percent of all medical negligence claims in Australia.[31]

Most cases could perhaps have been avoided by improving the communication process. A patient treated openly and honestly is less likely to complain when things go wrong. It is here that differences exist, not only between individual patient philosophies and expectations, but also between professionals' views. Differences exist between:

(i) what the patient wishes to know;
(ii) what the medical practitioner believes the patient should know; and
(iii) what the law requires the patient to be told.

It is the conflict between the medical and legal standards of communication that is the concern of this article. Some sort of balance needs to be achieved. The law, it seems, is moving more and more in the direction of preserving patients' rights, as consumers, to participate fully in their treatment processes. This is evident by the recent trends in common law actions for negligence; but it is even more apparent when one regards the doctor-patient relationship as yet another example of a relationship between a supplier of services and a consumer. The law is increasingly regulating the provision of services in an attempt to protect consumers. It requires suppliers, whether they be of goods or services, to be more and more accountable and responsible in their activities.

31. "Advice to GP's" Australian Doctor Weekly 17 June 1988, 32.

The concept of a doctor-patient relationship as nothing more than a simple supplier-consumer type relationship is something quite new for the medical profession. This is not to say that the medical profession has not previously gone about their task in an unprofessional manner. The point is, however, that the concern has essentially been with the task at hand; that is treating sick patients, and there has traditionally been less focus on such consumer orientated matters as consent, communication and provision of information.

Arguably, the dichotomy between the medical and legal positions can be reduced to the following:

(i) on the one hand, we have the medical profession, concerned to get on with their role in treating patients, yet at the same time trying to avoid the legal minefield of litigation by aggrieved patients who complain that they were not told; and

(ii) on the other hand, we have the law, seeking to protect patients as consumers and to uphold their desire to be fully involved in the treatment process.

The first step towards achieving some solution to the problem is to recognise, and accept, that what is really at issue is a concern about effective communication regardless of whether action be brought in negligence for lack of informed consent, or under the FTA for misleading or deceptive conduct. The notion of informed consent as such is really an unachievable ideal; but what is achievable is a more open and effective communication processes, as a means of satisfying the patients' desire to be informed and not to be misled or deceived. In this way, there need not be any conflict.

How can this be achieved? There are some recommendations in the recent joint Report of the Victorian, Australian and New South Wales Law Reform Commissions,[32] in which this whole area was examined after a number of detailed studies on patient and doctor expectations. The recommendations were essentially that guidelines should be drawn up setting out the recommended information to be supplied for particular procedures. The guidelines would be worked out by a special committee comprising the various groups whose interests were affected, particu-

32. Victorian Law Reform Commission *Informed Decisions About Medical Procedures* (Project no 24 1989); New South Wales Law Reform Commission (Project no 62); Australian Law Reform Commission (Project no 50).

larly, consumer/patients, doctors and lawyers.

Such an approach does go some way to addressing the issue, for in setting out information standards, albeit by necessity somewhat vague and general, it would at least alert those involved in the treatment process of the need for a better level of communication. Whether it is necessary to back up such guidelines with the full force of the law is really a question of enforcement and compliance. The Law Reform Commissions' recommendation is that non-compliance with these guidelines constitute a ground for a malpractice complaint under the various disciplinary provisions in legislation throughout the States.[33] It is also recommended that these guidelines be admissible in evidence in any legal proceedings in which it is alleged that a doctor has been negligent or guilty of misconduct.[34] It is, however, specifically noted that there should not be any statutory standard prescribed.[35] Whether or not these guidelines will have the full force of law or not really comes down to whether the desired result of better communication processes, can be effectively achieved by self-regulation before the heavy hand of the law has to be resorted to.

Information standards of this kind are not a new phenomenon in the general arena of consumerism, and such standards exist for example in the form of packaging and labelling requirements. Indeed, the FTA itself makes provision for the establishment of similar information standards to apply in the provision of services,[36] and depending upon the regulatory process adopted, there is already the means for establishing such standards as a legislative requirement in the supply of services.

The other means suggested to deal with this concern for better and more effective communication in the doctor-patient relationship is to address the issue at the preliminary stage during medical courses. The Law Reform Commissions recommended that medical courses should allow medical students the opportunity to consider these issues and perhaps discuss the information guidelines as a means of addressing the issues of communication and the nature of the information to be supplied to patients.

33. Victorian Law Reform Commission, ibid recommendation 4.
34. Ibid, recommendation 3.
35. Ibid, recommendation 1.
36. See FTA Part VI, Division 2.

Although these suggestions will not solve the problem overnight, they do go some way towards achieving a necessary compromise to the problem. An overly legalistic approach may ultimately result in negative returns, forcing medical practitioners to go on the defensive.[37] It really is a matter of finding a compromise - an appropriate means whereby a greater awareness of the various interests involved can be achieved so that it might act as a catalyst to change in both practice and attitude. In this way, the solution involves a process of education for all involved; the medical profession as well as the patients, so that the dichotomy between their respective expectations can be reduced.

37. For example, by tape recording all treatment sessions as is the case with some practitioners in the United States, and even by opting out in certain circumstances, acknowledging that the costs involved are just not worth the effort.