
Many mischiefs arise on the change of a maxim and rule of the Common Law, which those who altered it could not see when they made the change. [FN1]

INTRODUCTION

It has been suggested that the whole of the private law may be regarded as the law of consent. [FN2] The law of torts is based on the principle that subject to the law of the land, no one has the right to interfere with another person's physical and economic integrity and freedom without that person's consent.

This article examines the historical and jurisprudential evolution of the concept of consent in the law of trespass to person with an emphasis on issues associated with consent to, and refusal of, medical treatment. Consent to treatment and refusal of treatment have been regarded merely as obverse *2 sides of the same coin. [FN3] One of the premises of this article is that the law is inconsistent insofar as it considers consent to be a relative value while regarding refusal as an absolute and inalienable right.

For the purposes of this article, the phrase "life-saving treatment" is used to denote medical treatment (antibiotics to treat pneumonia, blood transfusions, certain organ transplants, cardiopulmonary resuscitation, and the like) administered to cure or stabilize a life-threatening but treatable and potentially reversible medical condition, usually in an emergency situation. The phrase also applies to medical treatment undertaken for the purpose of enhancing the quality of life for those patients who suffer from an incurable condition but who are conscious and not hopelessly ill, for instance, patients suffering from chronic renal failure, chronic hepatitis, or chronic lymphatic leukemia. The phrase "life-sustaining treatment" refers to such medical devices as a mechanical ventilator, a catheter, or a feeding tube, which are utilized to keep alive patients who are hopelessly ill because their vital functions are seriously impaired, but who are not terminally ill as, for example, persons in a coma or in a vegetative state. [FN4]

Medical and legal ramifications of utilizing the legal criterion of "sound mind" as it applies to the issue of consent to, and refusal of, life-saving treatment also will be broached. It is asserted that when assessing the decisional capacity of a patient to refuse life-saving treatment, the traditional notions of "sound mind" should be
modified to include modern medical understanding of affective competency. [FN5] This needs to be done to protect the vulnerable patients whose cognitive capacity may be intact, but whose decisional competency is impaired by illness or systemic disease.

As the title suggests, this article discusses concepts of consent to, and refusal of, medical treatment in the context of the tort of trespass. The tort of negligence is focused on the defendant. Under the law of negligence, one must guard against creating risks that may result in an injury to another when there exists a legal duty of care toward that other person. If a particular risk cannot be eliminated or minimized, then the risk ought to be disclosed to those who may be harmed by it. In cases of negligence relating to the physician-patient relationship, the central question is whether or not the defendant medical practitioner has complied with the duty to exercise reasonable care and skill in the provision of diagnosis, advice, and treatment to the patient. The breach of duty may involve a failure to disclose a reasonably foreseeable material risk. However, the patient can only sue in negligence for nondisclosure of the particular risk if the risk actually eventuates, causing an injury.

The issue of consent in negligence is thus relevant insofar as it helps to establish the standard of care expected of a medical practitioner in relation to provision of advice and information. Did the medical practitioner provide enough information to enable the patient to choose between undergoing or not undergoing the risky treatment in question? [FN6] In the case of Canterbury v. Spence, [FN7] the United States Court of Appeal for the District of Columbia said that the "patient's right to self-decision shapes the boundaries of the duty to reveal." [FN8] Consequently, the interest in bodily integrity commands "protection, not only against an intentional invasion by an unauthorized operation but also against a negligent invasion by his physician's dereliction of duty to adequately disclose." [FN9] To paraphrase, the right to decide what should be done to one's body is protected by the torts of trespass and negligence, but in different ways. The tort of trespass protects one's right to decide whether or not to consent to an interference. The tort of negligence protects one's right to be informed about the factors that will be material to that decision.

The law of trespass to person—as further explained below—focuses on the patient's right to be free of any unwanted bodily contacts and the right to decide whether or not such contacts should occur. Therefore, the ultimate issue of the physician's liability in trespass to person has to be determined by reference to the presence or absence of valid consent. In the case of Reibl v. Hughes [FN10], Chief Justice Laskin of the Canadian Supreme Court noted that he could appreciate the temptation to say that the genuineness of consent to medical treatment depends on proper disclosure of the risks which it entails, but . . . unless there has been misrepresentation or fraud to secure consent to the treatment, a failure to disclose the attendant risks, however serious, should go to negligence rather than to battery. Although such a failure relates to an informed choice of submitting to or refusing recommended and appropriate treatment, it arises as the breach of an anterior duty of due care, comparable in legal obligation to the duty of due care in carrying out the particular treatment to which the patient has consented. It is not a test of the validity of the consent. [FN11]

Likewise, the majority on the High Court of Australia, in the case of Rogers v. Whitaker, [FN12] rejected the American doctrine of informed consent in the context of the law of negligence. [FN13] The High Court described the phrase "informed consent" as "somewhat amorphous," and "apt to mislead as it suggests a test of the validity of a patient's consent." [FN14] Furthermore, the High Court commented that the expression "the patient's right to self-determination" is "perhaps, suitable to cases
where the issue is whether a person has agreed to the general surgical procedure or treatment, but is of little assistance in the balancing process that is involved in the determination of whether there has been a breach of the duty of disclosure." [FN15]

Legal authorities in the United States, Australia, Canada, England, and New Zealand are drawn upon throughout this article. The decisions cited may carry merely a persuasive weight in different jurisdictions. However, it is not the goal of this article to set out authoritatively the law of consent and refusal in any given jurisdiction, but rather to explore and understand these concepts with reference to the case law.

I. MODERN LEGAL UNDERSTANDING OF TRESPASS TO PERSON AND THE ROLE OF CONSENT

Consent as a legal concept developed originally within the context of the law of trespass. Trespass is a generic term that encompasses all kinds of wrongful direct and intentional interferences with persons, land, and chattels (goods). Trespass to person comprises three separate torts--battery, assault, and the tort of false (wrongful) imprisonment. [FN16] This article concentrates on the concept of consent in relation to the tort of battery.

The modern tort of battery has been defined as an intentional wrong "which is committed by intentionally bringing about a harmful or offensive contact with the person of another." [FN17] This will happen when the direct offensive contact with the body of another had been desired (purposive) or known to be substantially certain to result. [FN18] The tort is based on the principle that other persons do not have the right to interfere with the person of another unless he or she validly consents to such an interference. [FN19] The law considers the tort of trespass to person as safeguarding not only the personal interest in one's physical integrity, but also as protecting the individual against any interference that is offensive to a reasonable sense of dignity and personal autonomy.

The notion of autonomy (from Greek "autos" (self) and "nomos" (rule) expounds that every individual has the legal right to personal self-determination. In bioethics, the terms "autonomy" and "respect for autonomy" are associated with several ideas, such as privacy, voluntariness, choosing freely, and accepting responsibility for one's choices. [FN20] In law, the modern doctrine of autonomy is expressed through the rule that each competent individual has the right to noninterference with his or her choices, imposing upon others an obligation not to constrain unnecessarily the autonomous decisions and actions of a competent person. [FN21]

Generally, in a medical context, the conduct of the treating physician will be intentional, and will have an effect of causing contact with the adult patient's body. The trespassory contact may lose its wrongful character if the physician can provide evidence of valid consent, statutory authorization, [FN22] or lawful justification, [FN23] but if there is no evidence on the issue, any medical intervention, no matter how benevolent in motivation, may constitute battery. [FN24] With respect to medical treatment, Justice McHugh of the High Court of Australia articulated the nature of the modern tort of trespass in the following way:

It is the central thesis of the common law doctrine of trespass to the person that the voluntary choices and decisions of an adult person of sound mind concerning what is or is not done to his or her body must be respected and accepted, irrespective of what others, including doctors, may think is in the best interests of that particular person. [FN25]

The courts regard the role of consent in trespass as generally having the effect of transforming what would otherwise be unlawful contact into accepted. *6 and
acceptable, conduct. Therefore, consensual contact does not, ordinarily, amount to battery. [FN26] For the purposes of medical practice, the legal function of consent is to "provide those concerned in the treatment with a defence to a criminal charge of assault or battery or a civil claim for damages for trespass to the person." [FN27]

The patient's right to make decisions about medical treatment has been identified with the legal right to self-determination. For instance, in the case of In re Conroy, [FN28] the New Jersey Supreme Court stated: "On balance, the right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death." [FN29]

The right to refuse a life-saving treatment is commonly referred to as the "right to die." Justice Robins of the Ontario Court of Appeal gave the following jurisprudential explanation for the "right to die":

The right of self-determination which underlies the doctrine of informed consent also obviously encompasses the right to refuse medical treatment. A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternate form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community. Regardless of the doctor's opinion, it is the patient who has the final say on whether to undergo the treatment. [FN30]

In the United Kingdom, Lord Goff of Chieveley in the case of Airedale NHS Trust v. Bland, [FN31] defined the patient's right to refuse medical treatment including life-saving treatment in a similar fashion:

[T]he principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so.

Hence, the legal status accorded to refusal of medical treatment, including life-saving treatment is formulated in terms of decision-making process, whereby refusal is seen as negatively equipollent with a consent to treatment. But are these two concepts, particularly consent to, and refusal of, life-saving treatment, truly equipollent?

*7 II. HISTORICAL OVERVIEW OF THE CONCEPT OF CONSENT IN THE COMMON LAW OF TORTS

To evaluate whether concepts of consent to, and refusal of, life-saving treatment are equivalent, it is important to understand the origins and the evolution of the law of consent. The common law of trespass developed to provide an alternative remedy to the deeply ingrained custom of blood feud through the law of vengeance--family feud known as "faida"--at the time when customary law was incapable of creating legal institutions that could enforce or maintain civil order within the community. The customary law of vengeance was based upon a highly sensitized understanding of family honor and loyalty combined with the basic instinct to retaliate. It generally was invoked for murder, adultery, violation, or rape of a married woman, violation of the dead, aggravated robbery, and, importantly, any insult to the honor of the family. The law of vengeance was open to all ranks among the Germanic and the Frankish people of the early Middle Ages and neither the Royal authority nor the Church were able to suppress it. [FN32]

When, in 1252, the Chancery commenced to issue writs [FN33] of trespass, their primary purpose was to replace the customary laws of faida with the public machinery
of legal process manifested by criminal prosecution. [FN34] The objective behind the original writ of trespass "vi et armis et contra pacem Domini Regis" (with force and arms and contrary to the King's peace) was the punishment of offenders against the royal peace. [FN35] Procedurally, the allegation in the pleadings that an offense against the royal peace had been committed, was necessary to bring the culprit before the royal courts, and away from the customary and baronial courts. Because forcible trespass involved a breach of the royal peace and so was in itself wrongful, personal damage was not a necessary element of liability.

Under the Salic, Anglo-Saxon, and Anglo-Norman laws, there was a *8 procedure in cases involving serious offenses, whereby the guilty party could pay a compensation, "wergeld," (the monetary equivalent of a human life) to the victim of his or her kin in an attempt to preclude the risk of private war. Although the new machinery of justice under the Angevins tended to impose punishments without compensation, in cases of homicide, rape, and wounding, the old custom of wergeld-type compensation survived but was adapted to the new judicial system of royal courts. [FN36] Until 1694, a defendant found liable in a civil action for trespass, besides being mulcted in damages in favor of the injured plaintiff, also had to pay a fine to the Crown. Thus, even after the civil tort of trespass evolved, it did so without losing its criminal law characteristic of being primarily an offense against the royal or public peace. [FN37]

Initially, forcible trespass was interpreted literally—with force of arms against the Royal peace. It soon, however, came to be interpreted as meaning any direct and intentional invasion of the plaintiff's rights that may lead to instant retaliation or vengeance, and hence to the breach of the peace. [FN38] Because consent negates the threat of revenge, the plea of consent generally would have the effect of transforming the otherwise unlawful conduct into legally acceptable conduct. The plea of consent is different from the defense based on the maxim that is today known as "volenti non fit injuria" (no wrong is done to the one who consents), [FN39] loosely derived from Roman law. [FN40] The maxim was expressed by Bracton (c 1200-1268) in the De Exceptionibus section of his De Legibus at Consuetudinis Angliae [FN41] as "cum volenti at scienti non fiat iniuria" (with consent and knowledge no injury is done). Though the word "scienti" was later eliminated, knowledge of the risk of injury being consented to has remained an element of the "volenti" defense, which is based upon the principle that a person should have the right to waive his or her legal rights. Sir Donaldson MR (as he then was), in Freeman v. Home Office, [FN42] pointed out that the maxim of "volenti non fit injuria" provides a bar to enforcing a cause of action; it does not negative the cause of action itself. [FN43]

Originally, however, the requirement of consent did not indicate the law's concern for the individual's right to self-determination, or even the *9 personal right to physical integrity. Rather, the presence of voluntary consent indicated that the plaintiff was willing to forego the right to revenge. Hence, the question of consent was merely a factor in the enforcement of the peace of the realm.

The law looked at consent as an evidentiary factor relating to the issue of non-liability—the denial (in pleading terminology, a traverse) of one of the elements of the cause of action in trespass. [FN44] For instance, the Nottingham Eyres [FN45] rolls for 1329 record the pleadings, known as The Surgeon's Case, of a patient-plaintiff who complained that the defendant surgeon having undertaken "to cure his eye with herbs and other medicines," instead "put out his eye, so that he lost it, to his damages." According to the Launde, as the plaintiff
put himself under his [defendant's] medicines and cure, no trespass can be found in him at that time, since he himself submitted to his cure, hence, if he had any action at all it would naturally sound in covenant broken, so we ask judgment whether such bill should be received. [FN46]

The defendant pleaded that the patient-plaintiff was unable to use the writ of trespass for battery because he had consented to the cure, thus depriving the surgeon's conduct of its trespassory character. [FN47]

In 1704, Chief Justice Holt, in the case of Cole v. Turner, [FN48] summed up the medieval perception of the cause of action in trespass to person when he said that "the least touching of another in anger is a battery." The concept of consent formed a part of a strictly communitarian system of values and ethics. Therefore, the right to consent to an interference with one's body, though protected by the law through the writ of trespass, was never regarded as an absolute value in itself.

In the Leviathan or the Matter, Forme and Power of a Commonwealth Ecclesiastical and Civil, [FN49] first published in 1651, Thomas Hobbes wrote that no man can be understood to consent to be wounded, chained, or imprisoned. The right of consent was always qualified by the policy considerations of upholding the public order, and was articulated in the rule that *10 where "a man license another to beat him, such licence is void as it is against the peace." [FN50] In the United States, the Superior Court of New Jersey reiterated this rule in the case of State v. Brown, [FN51] when it refused to regard as valid the consent of a wife to being beaten by her husband with his hands "and other objects" if she got drunk. The court reasoned that to allow such a defense would "threaten the dignity, peace, health and security of our country." [FN52]

From early medieval times, the plea of consent did not suffice to exculpate the defendant from the charge of murder following a premeditated and intentional killing in the course of a fight. [FN53] Similarly, the law of maims and the crime of malingering are historical examples of the law setting its face against validating the individual's right to consent to what should be done to his or her body in these instances. The reason for the refusal to hold valid consent to self-mutilation or mutilation of the consenting person by another was to ensure that sufficient numbers of able young men were ready to be pressed into service with the Royal army and navy. The primary aim of the law of maims was to prevent the practice of beggary. Coke, in his Institutes of the Laws of England, [FN54] quotes a case where a young and healthy youth asked his friend to maim him, so that he could beg more effectively. Both the young man and his friend were found guilty of mayhem.

The personal right of refusal to an outside interference with one's bodily integrity was protected by law only if the refusal entailed prevention of, or a refusal to participate in, wrongs that were seen as threats to the communitarian principle of preserving public peace. While the institution of serfdom persisted, a serf had no legal right to refuse physical interference with his or her body, for only free men had the right to seek a remedy in the royal courts. Even amongst the free subjects, the two long-lasting exceptions to the tort of battery, namely, the right of the parent of teacher to chastise children and pupils, [FN55] and the husband's right to beat his wife, have been conspicuous examples of the law's disregard for the individual's right to refuse harmful and demeaning contact.

As civil society developed, jurisprudential emphasis shifted away from the tort of trespass as the primary vehicle for safeguarding the royal peace. The somewhat restricted concept of personal freedom, as developed in classical Greece, was revived in the 17th century to indicate that a personally*11 free individual is a person who is...
"owner of his own body" in contrast to the slave who, although a human creature, does not possess such self-ownership. This articulation of personal freedom is evident in a number of Periclean funeral orations. [FN56] In the 17th century, John Locke adopted the possessory notion of personal self-ownership, as against enslavement of the self, [FN57] when he developed the theory of property. [FN58] Political theories of personal liberty and proprietary freedom propounded by John Locke and Thomas Hobbes, in the wake of the English Civil War, and based upon the notion of self-ownership, became, in the course of the 18th century, a "deep-seated popular feeling in favour of liberty" at the expense of the power of the state. [FN59] The most manifest common law reflection of these popular feelings was the identification of personal privacy with proprietary interests and the affirmation of the principle that "by the laws of England, every invasion of private property, be it ever so minute, is a trespass. No man can set his foot upon my ground without my licence, but he is liable to an action, though the damage be nothing." [FN60]

In the second part of the 18th century, Sir William Blackstone extended the scope of the tort of trespass to person to all nonconsensual contacts by eliminating the requirement of violence. Blackstone wrote that "the law cannot draw the line between different degrees of violence, and therefore totally prohibits the first and lowest stage of it: every man's person being sacred, and no other having a right to meddle with it, in any the slightest manner." [FN61] For Blackstone, the rationale of the prohibition of all nonconsensual contacts lay in the sacredness or inviolability of the human person. He argued that there exists an absolute right to personal security, vested in each person: "The right of personal security consists in a person's legal and uninterrupted enjoyment of his life, his limbs, his body, his health, and his reputation." [FN62] As an inviolate legal right, the principle of sacredness of human person was operative both in public and private spheres.

*12 A. The Emergence of the Concept of Consent Within the Physician-Patient Relationship

The Hippocratic tradition regarded the practice of medicine as art consisting of three components--the disease, the patient, and the physician. The Hippocratic physician was encouraged to aspire to personal virtues of holiness and purity, and to follow professional ethics of compassion, knowledge, and dedication to the patient's welfare, as well as the obligation to transmit medical knowledge. These principles were expressed in the Hippocratic Oath, [FN63] and such other writings of the Corpus Hippocraticum [FN64] as On the Physician, Precepts, Aphorisms, and On Decorum, [FN65] which together created the system of medical deontology, based largely on the philosophy of the Pythagorean sect. [FN66] The Pythagoreans ranked medicine together with music and mantic as supreme sciences, and believed that their pursuit was the best way to express "love for what is truly noble." [FN67] Deontological principles imposed upon a physician a duty and "the obligatory doing of things because they are, quite simply, the right things to do" in caring for each individual patient. [FN68]

The deontological system of medicine as presented in Corpus Hippocraticum, and in particular the Hippocratic Oath, [FN69] was permeated with Pythagorean philosophy and consequently was not a representative of the classical Greek philosophy as a whole. In fact, the injunction "I will neither give a deadly drug to anybody if asked for it, not will I make a suggestion to this effect," [FN70] was unique to the small Pythagorean sect whose adherents were opposed to suicide believing that there was an inherent value in human life. Because God allocated to
humans their position in life as a post to be held and defended, it was a sin to disobey the divine command to live. [FN71] Ludwig Edelstein, one of the greatest scholars of ancient Greek and Roman medical literature, pointed out that in the eyes of a Hippocratic physician, *13 unless the physician abstained from suggesting or assisting in a patient's suicide, the physician, no less than the patient, was guilty of moral and religious transgression. [FN72] The Pythagorean view of suicide was opposed to that of Platonists, Cynics, and Stoics, all of whom held suicide permissible for the diseased. Although Aristotelians believed that it was cowardly to succumb to bodily pain, and the Epicureans insisted that people should not be subdued by illness, they condoned suicide in other circumstances. [FN73] In Roman times, Seneca expressed the Stoic view of suicide in the following terms: "When either nature demands my breath again, or reason bids me dismiss it, I will quit this life, calling all to witness that no one's freedom, my own least of all, has been impaired through me." [FN74]

One may ask why, in view of its minority status, [FN75] the Hippocratic school with its life-oriented philosophy, prevailed over the more populous medical schools or sects that were better attuned to the accepted mores of the times. [FN76] One explanation may be that when it came to the "crunch," patients preferred to seek help from physicians who adhered to a strict code of ethical principles, which prohibited medically assisted suicide. Nevertheless, general tolerance of suicide in Greek and Roman society meant that Hippocratic physicians would have encountered patients who either asked for assistance with suicide, or who, wishing to die, refused to comply with the prescribed therapy. Hippocratic physicians were advised not to undertake treatment of persons in the terminal stages of their disease, nor could they impose therapy upon those who did not want their services. But there also would have been patients who, having sought medical help, refused or were unable to comply with the prescribed therapeutic regime. The Hippocratic physicians stressed the importance of nursing in the healing process. They made frequent visits to their patients, and tended to leave one of their pupils behind to watch over and help with medical care for the sick. [FN77] They also provided a room in their own homes for treating patients who lived too far away for adequate supervision. [FN78] *14 The provision of nursing care was not only beneficial to those patients who cooperated with the physician in wishing to get well, but was also helpful in overcoming or mitigating passive refusal or noncompliance with treatment.

It does not appear that seeking an express consent to treatment from the patient constituted an integral part of the Hippocratic tradition, which was based on a covenantal relationship between physician and patient, rather than on the modern principle of consensual partnership. Central to a covenantal relationship is the ethical principle of trust with its corresponding duties and obligations. The Hippocratic physician-patient relationship presupposed that "if the physician [was] going to help, his relationship to his patient must be that of the person in command to the one who obeys." [FN79] Probably the most famous of the Hippocratic Aphorisms affirms that "Life is short, art is long; opportunity is fleeting, experiment is dangerous; judgment is difficult. It is not enough for the physician to do what is necessary, the cooperation of the patient and the attendants must be secured, and circumstances must be favourable." [FN80]

The relationship in which a patient was expected to cooperate and to put "himself and 'his all' into the hands of the physician" involved a recognition that the patient's trust reposed in the physician encompassed not only the latter's knowledge and skills, but also the person. The principle of the patient's trust imposed upon the physician
obligations that included the code of personal ethics prescribed in the Hippocratic Oath, and other writings of the Corpus Hippocraticum. These writings present the model of a physician as a composite of a person adhering to the ideals of the Pythagorean philosophy [FN81] with the Aristotelian qualities of a "gentleman" (kindness, self-control, regularity of habits, justness and fairness, a proper and good behavior), [FN82] as well as the Stoic virtues of wisdom [FN83] and charity toward all people--free citizens, slaves, and barbarians, including those who are impecunious. [FN84]

The Hippocratic ideas persisted in an unbroken line following the decline of Roman civilization through the early Middle Ages. Even though *15 the Christian Church authorities did not approve of pagan writings, some segments of the Hippocratic Corpus were known, and treatises on the ethics and etiquette of medicine written by monks in North European monasteries rendered into a "Christianized" version the pivotal deontological aspects of the Corpus Hippocraticum. [FN85] The essential model of the covenantal physician-patient relationship based on a patient's obedience and trust also was adopted by Moslem and Arabic-speaking Jewish physicians who became the intellectual heirs, custodians, and translators of the works of Hippocrates, Aristotle, and Galen into Hebrew and Arabic. [FN86] The classical tradition in Europe was revitalized when the scholars of the University of Salerno, which was created as "civitas Hippocratice" at the end of the 9th century, began to translate into medieval Latin, the Hebrew and Arabic manuscripts containing the works of Greek, Roman, and Jewish medical writers. [FN87] The medieval Latin translations, however, focused upon the practical aspects of medicine, rather than on general theoretical principles. [FN88]

The absence of any discussion of the issue of consent in the early Middle Ages reflected the feudal law's preoccupation with landed property, the intricacies of the vassalage system, and fiscal privileges. It was only with the advent of the Renaissance and loosening of feudal controls of obligation and privilege that there emerged a philosophical shift toward examination of the rules governing the relationships between individuals--as distinguished from collective rights and duties of the representative "estates," social classes, and industrial guilds. The orientation of the law toward an individual was accelerated by the rediscovery in 1100 in Italy of the Corpus iuris civilis of the Emperor Justinian, which was originally compiled between 533 and 556 CE. The opening sentences of the Institutiones (Institutes) of Justinian: "Iustitia est constans et perpetua voluntas ius suum cuique tribuens" (Justice is the constant and perpetual purpose of giving to each his due), and "Iuris prudentia est divinarum atque humanarum rerum notitia, iusti atque iniusti scientia" (Jurisprudence is the knowledge of things divine and human, the science of just and the unjust) [FN89] became the foundation of the modern jurisprudence. [FN90] *16

The principles of the medieval Roman or "civil" law based on the Corpus Iuris were taught in all European universities from Salerno and Bologna, to Paris, Oxford, and Cambridge. [FN91] Late medieval philosophers, many of whom studied Roman law at university, were the first to analyze, though from different perspectives, the internal experiences of man as an individual. [FN92] These 13th and 14th century thinkers, amongst them Giovanni Bonaventura, Roger Bacon, John Duns Scotus, Johannes Eckhart, and William of Ockham, paved the way for the revival of classical Greek and Roman learning, [FN93] and a critical re-evaluation of medieval scientific, moral, philosophical, and social dogma in light of the earlier conventions. In a way, the Renaissance rediscovered an individual as a physical being--an object to be studied by anatomists, described by philosophers, and portrayed by artists.
For centuries, midwives, herbalists, gymnastic trainers, "purifiers," and purveyors of charms, incantations, and drugs--as well as physicians--claimed the ability to heal the sick. At the same time, it is known that at least since the beginning of the 15th century, English physicians desired to have standards of entry into their profession regulated. In 1421, the physicians placed before parliament a petition requesting that "no man, of no manner, estate, degree, or condition, practice in Physic, from this time forward, but he have long time used the Schools of Physic within some University, and be graduated in the same." [FN94] Under the statutes and the common law of medieval England, anyone could practice medicine or surgery with the consent of the patient. However, when the patient died while under the care of a person who was not licensed by the Church, guild, or university to practice medicine or surgery, such a death was held to be a felony. [FN95]

In the England of the 16th century, medicine was taught as a postgraduate course in the Arts faculties of Oxford and Cambridge and consisted mainly of exposition of classical authorities such as Aristotle and Galen with little scientific instruction or clinical training. When the (Royal) College of Physicians of London was created in 1518 under the Chancellorship of *17 Cardinal Wolsey, [FN96] in the preamble to the College's charter, Henry VIII expressed a desire that the Royal Physicians should promote medical learning through encouragement of the new Italian medical humanism. [FN97] The primary purpose of the College of Physicians was to control the practice of medicine. At first, however, the influence of the College of Physicians was confined to the metropolitan area extending seven miles from the City of London. [FN98]

In 1523, the jurisdiction of The Royal College of Physicians extended to the whole of England, and the College was granted judicial powers to regulate educational qualifications and standards of medical practice amongst its members. [FN99] Yet, for a long time, the powers of the College, particularly outside of London, were more apparent than real. This was because although the Royal College was granted power to adjudicate on the candidate's educational competence to practice medicine, the bishops had retained power to grant the license to practice medicine within their dioceses. [FN100] Nevertheless, in the course of the following two centuries, ethical codes aiming to lift the standards of medical practice were revised and adapted to the spirit of the nascent Enlightenment with its "quest for immutable laws of nature, of man, and in philosophy." [FN101] Guided by reason rather than religion and received dogma, the Enlightenment placed at the center of its concerns the nature of individual rights and liberties within civil society. [FN102]

Physicians, whether members of the College or not, began to critically review contemporary medical practice. [FN103] In 1556, John Securis published a book entitled A Detection and Querimonie of the Daily Enormities and Abuses Committed in Physick, which was aimed at reforming the morality and practice of medicine. [FN104] In the 17th century, Thomas Sydenham, an *18 adherent of the new empirical scientific method, known as the "English Hippocrates," stressed that the aim of medicine was to treat the patient, not disease. [FN105] Subsequently, in 1711, a London physician, Dr. Bernard Mandeville, wrote A Treatise of the Hypochondriack and Hysterick Passions, Vulgarly Called the Hypo in Men and Vapours in Women, which was intended for the education of patients as well as physicians. [FN106]

In his influential Lectures on the Duties and Qualifications of a Physician, published in 1772, John Gregory [FN107] argued that it was the ethical and professional conduct of physicians that enabled the fusion of the two divergent
conceptions of the profession of medicine to be sustained, namely the concept of medicine as "an art the most beneficial and important to mankind, or as a trade by which a considerable body of men gain their subsistence." [FN108] Gregory stressed that the scientific learning and professional skill of every physician must be tempered by "the obligation to humanity, patience, attention, discretion, secrecy, and honour, which he lies under to his patients." [FN109] Moreover, "it is a physician's duty to do everything in his power that is not morally criminal to save the life of his patient," [FN110] though "even in cases where his skill as a physician can be of no further avail, his presence and assistance as a man and as a friend may be grateful and useful, both to the patient and his nearest relations." [FN111]

Gregory noted that within the covenantal physician-patient relationship "the government of a physician over his patient should undoubtedly be great, but an absolute government very few patients will submit to." [FN112] He defined the rights of patients in a covenantal relationship in the following way:

"Every man has the right to speak where his life or his health is concerned, and every man may suggest what he thinks tends to save the life of his friend. It becomes them to interpose with politeness, and deference to the judgment of the physician; it becomes him to hear what they have to say with attention, and to examine it with candour. [FN113]

The physician must respect his patients' opinions and therapeutic preferences, *19 provided that these preferences are consistent with the patient's safety:

Sometimes a patient himself, sometimes one of his friends, will propose to the physician a remedy, which, they believe, may do him service. Their proposal may be a good one; it may even suggest to the ablest physician, what, perhaps, till then, might not have occurred to him. It is undoubtedly, therefore, his duty to adopt it. [FN114]

Consent to medical treatment, as we understand this concept today, was not specifically articulated in the medical treatises, professional codes, and regulations of early modern England. [FN115] Nevertheless, the notion of patient consent to treatment not only as a legal requirement but also as an ethical construct must have been appreciated, because its legal and ethical significance within the physician-patient relationship was discussed in the 1767 English case of Slater v. Baker & Stapleton. [FN116] This case appears to be a first instance in which the court affirmed the principle that nonconsensual contact in the context of medical treatment ought to be regarded as a legal wrong. [FN117]

The plaintiff, Slater, sued a surgeon and an apothecary in special action on the case [FN118] for "ignorantly and unskilfully" --over his protests-- refracturing "the callous" (bony material present during healing) of his leg after it was set and placing it in an "extension" instrument thereby causing him an injury. The medical expert witnesses called by the plaintiff testified that it was contrary to the standard practice to refracture a leg unless the bone was setting very badly. They also testified that the use of the extension instrument of the kind employed by the defendants to stretch and straighten the limb during healing was not approved of by the profession. A surgeon expert witness swore "that if the plaintiff was capable of bearing his foot on the ground, he would have disunited the callous if it had been desired by him, but in no case whatsoever without the consent of the patient." [FN119] The jury awarded the plaintiff £500.

On appeal, the defendants argued that because there was no evidence of ignorance or want of skill (the defendant Baker was apparently the first surgeon in St. Bartholomew's Hospital in London for 20 years), the essence *20 of the complaint lay in the fact that the leg "was broke without the plaintiff's consent." Therefore, the
appropriate writ was that of trespass "vi at armis" (battery). This was a technical argument designed to defeat the plaintiff's action on the issue of suitability of the writ: if the writ did not fit the facts of the case, it could be quashed, and, in accordance with the maxim "no writ, no remedy," the plaintiff would be left without legal relief. However, the court of the King's Bench rejected the arguments of the defendants. Referring to the evidence about the good character of Baker, the full court noted that "many men skilful in their profession have frequently acted out of the common way for the sake of trying experiments. It seems as if Mr. Baker wanted to try an experiment with this new instrument." [FN120] As such, his action was rash "and he who acts rashly acts ignorantly." [FN121] The full court refused to nonsuit the plaintiff on the basis that the proper writ would have been trespass "vi at armis":

In answer to this, it appears from the evidence of the surgeons that it was improper to disunite the callous without consent; this is the usage and law of surgeons: then it was ignorance and unskilfulness in that very particular, to do contrary to the rule of the profession, what no surgeon ought to have done; and indeed it is reasonable that a patient should be told what is about to be done to him, that he may take courage and put himself in such a situation as to enable him to undergo the operation. [FN122] It is interesting to note the 18th century court's disapproval of medical experimentation on human subjects without their consent. The court considered the surgeons' failure to explain the experimental nature of the procedure, and their disregard of the patient's refusal to undergo the operation as an "improper" breach of professional conduct, presumably in violation of the code of the Barber-Surgeon's Company of London.

Rather than elaborating upon strictly legal principles relating to consent, the court explained why it is bad professional practice to keep patients ignorant of the nature of proposed therapy, and to treat them without consent. Two and a quarter centuries after the judgment in Slater v. Baker & Stapleton, Lord Donaldson of Lymington MR, [FN123] provided a very similar description of the clinical purpose of consent to medical treatment. He said that consent of the patient is essential in clinical practice because it encourages the cooperation of the patient and ensures the patient's faith--or at least *21 confidence--in the efficacy of the treatment, and thus contributes to the treatment's success. [FN124]

Because of the nature of the writ under which the plaintiff pursued his cause of action in Slater, the question of whether the treating practitioners' failure to explain the nature of the intervention and the disregard of the patient's refusal to undergo the treatment should sound in damages in trespass remained unanswered. The plaintiff's action was essentially to recover damages for the bodily damage he had suffered as a result of the defendants' refracturing the leg and then placing it in an experimental apparatus. The injury to his dignitary interests, as manifest through the surgeons' disregard of his refusal, was treated not as an ultimate issue, but as an evidentiary factor in the determination of the defendants' liability for malpractice.

In Thomas Percival's seminal book on medical ethics, [FN125] which was originally published in 1803, [FN126] Percival does not refer specifically to the case of Slater v. Baker & Stapleton. Nevertheless, he may have had in mind practices similar to those that gave rise to the lawsuit when he wrote that experimental treatments in medicine and surgery should not be undertaken without proper consultation between all concerned, and only in accordance with sound reasons. Although it has been claimed that research and experimentation are a normal part of clinical practice, in the sense that "every clinical decision ought to involve an experiment," [FN127] there is a fundamental distinction between an ordinary
therapeutic physician-patient relationship, and a relationship that exists between physician-investigators and patient-subjects. Within the therapeutic physician-patient relationship, the focus of the physician's attention and care is the patient and his or her best interests. When this relationship is altered to accommodate experimental treatment, the physician-investigator has to consider factors that are extraneous to the patient's best interests. [FN128]

Percival does not discuss the specific issue of consent to, or refusal of, a proposed treatment by a patient. However, he urges respect for the patient's wishes even in circumstances where the treating physician may disagree with them:

The feelings and emotions of the patients, under critical circumstances, require to be known and to be attended to, no less than the symptoms of their diseases. Thus, extreme timidity, with respect to venaesection, contraindicates its use, in certain cases and constitutions. Even the prejudices of the sick are not to be contemned [sic], or opposed with harshness. [FN129]

Likewise, Percival makes the following observations:

The use of quack medicines should be discouraged by the faculty, as disgraceful to the profession, injurious to health, and often destructive even of life. Patients, however, under lingering disorders, are sometimes obstinately bent on having recourse to such as they see advertised, or hear recommended, with a boldness and confidence, which no intelligent physician dares to adopt with respect to the means that he prescribes. In these cases, some indulgence seems to be required to a credulity that is insurmountable: And the patient should neither incur the displeasure of the physician, nor be entirely deserted by him. He may be apprised of the fallacy of his expectations, whilst assured, at the same time, that diligent attention should be paid to the process of the experiment he is so unadvisedly making of himself, and the consequent mischiefs, in any, obviated as timely as possible. [FN130]

Percival adds that "certain active preparations, the nature, composition, and effects of which are well known, ought not to be proscribed as quack medicines." [FN131]

The writing of Gregory and Percival illustrate the core virtues that characterize a humane and benevolent physician of the Enlightenment: scientific approach to evaluation and application of medicinal drugs combined with compassionate care based on nonjudgmental understanding of vulnerabilities, wishes, and needs of those who suffer from illness and disease.

Insofar as Percival was opposed to providing the patient with theoretical reasons for the treatment and the nature of remedies to be prescribed, [FN132] modern bioethicists would describe his attitude as "paternalistic," based on an assumption that the physician knows better than anyone, including the patient, what is best for the patient. John Gregory, in his Lecture II, discussed certain psychological, sociopolitical, and religious considerations why it was wise for the 18th century physician to avoid disclosure to the patient of the properties of medicines and remedies to be employed in the course of therapy. [FN133] Gregory noted that there were cases "where it may be proper to acquaint a patient with the nature of the remedies, as there are sometimes peculiarities in a constitution, in regard both to the quality and quantity of the medicine, which a physician ought to be informed of before he prescribes it." [FN134] The decision to forego explanations probably was an expression of professional honesty, for it was often more honest for an 18th century physician--whose practice was guided as much by intuition and clinical experience as by scientific knowledge--to say little or nothing about the benefits and risks involved in a particular course of therapy or medication, than to provide a spurious pseudo-scientific explanation. These considerations, however, did not relieve
medical practitioners from an ethical obligation to inform patients that a proposed
treatment was novel or experimental.

The term "consent," applying to interpersonal relationships, is absent from the
texts of Gregory and Percival. In fact, it was only toward the end of the 18th century
that Henry Ballow defined this word in his Treatise of Equity, which was published
posthumously, in 1793, with annotations by John Fonblanque. [FN135] The authors
were influenced by the theories of Hugo Grotius, who published De Iure Belli ac
Pacis (on the Law of War and Peace) in 1625, and by Samuel Pufendorf, who built
upon the earlier work of Grotius, in authoring two treatises De Iure Naturae et
Gentium Libri VIII (1672) and De Officio Hominis et Civis Iuxta Legem Naturalem
Libri II (1673). [FN136] Grotius and Pufendorf sought to establish a body of certain
basic and universal principles that would be binding on all people, irrespective of the
time and the place in which they lived. [FN137] They argued that these principles,
like, for example, the obligation to carry out one's promises, had the same certainty
and generality as a proposition in mathematics. [FN138] The body of the basic or
axiomatic principles was called natural law, in the sense that they were arrived at by
means of rational study and critical observation of human nature and relationships.
Concrete rules, which applied to specific areas of law, could be deduced from general
concepts and axioms. According to Grotius, the axiomatic principles of natural law
were drawn from "the principles of nature, or common consent." [FN139] In English,
this theory of the "law of reason" (Vernunftrecht) is referred to as the School of
Natural Law. Its legal methodology and ideology were closely linked with the
political and philosophical ideas of the Enlightenment.

It is of significance, however, that the legal analysis of the nature of consent as an
aspect of interpersonal relationships should have been undertaken *24 first in the
context of the developing law of contract refracted through equity jurisprudence. In
the late 18th century, the gist of the law of contract was perceived as involving the
terms of an agreement made by consenting minds of the contracting parties who were
presumed to be equal. The focus of the law of contract was the damage occasioned by
the breach of a contractual term. Equity's role was to concentrate upon the persons
who are parties to the contract in order to ensure that "no one may be gainer by
another's loss," [FN140] in the sense that in a relationship in which a transfer of
proprietary interests is effected, the stronger party should not be allowed to take
advantage of the weaker one. Originally, the law emphasized the consensus of mind
by the contracting parties as an indication of true consent. This approach was known
as the "subjective theory" of contract. Today the preferred doctrine is the "objective
theory," whereby the law is less concerned with the true intentions of the parties and
more with outward manifestations of those intentions. [FN141] Eventually, the nature
of consent within the physician-patient relationship would come to be examined in the
light of this modern theory.

In the Treatise of Equity, Ballow and Fonblanque discussed the nature of consent
in the context of the law of agreements pertaining to transfer of property. However,
their analysis had wider implications. Grotius, in De Jure Belli ac Pacis, [FN142]
de fined consent as "an act of reason accompanied with deliberation." [FN143] Ballow
enlarged upon Grotius' definition by suggesting that deliberation indicated "the mind
weighing, as in balance, the good and evil on either side." [FN144] Fonblanque in the
annotations, relying on Pufendorf's De Iure Naturae et Gentium Libri, explained the
constituent elements of consent in the following way: "Every true consent supposes,
1st, a physical power: 2dly, a moral power of consenting; 3dly, a serious and free use
of them." [FN145]
In the United Kingdom, Australia, and Canada, the law considers consent to medical treatment as "real" or "valid" for the purposes of battery if it is given by a competent person who has made the decision voluntarily upon being informed in broad terms of the nature of the procedure that is to be performed. [FN146] This approach differs from the position adopted by the United States Court of Appeals for the District of Columbia *25 in Canterbury v. Spence, [FN147] which explained that to be valid, the consent has to be "informed": "True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each." [FN148]

This modern description of the nature of consent may have its source in a first century letter by Pliny the Younger to Catilius Severus. In the letter, Pliny describes the suicide of Titius Aristo who, suffering from protracted illness, called Pliny together with a few intimate friends and told them "to ask the doctors what the outcome of his illness would be, so that if it was to be fatal he could deliberately put an end to his life, though he would carry on with the struggle if it was only to be long and painful . . . ." [FN149] Pliny commended Titus Aristo for this course of action, and commented that "m any people have his impulse and urge to forestall death, but the ability to examine critically the arguments for dying, and to accept or reject the idea of living or not, is a mark of a truly great mind." [FN150] The original Latin text places more emphasis on the reasoning process, and speaks in terms of "deliberating and weighing one's causes for such decision," and the "counsel of reason." [FN151]

However, it seems that a more immediate source for the legal notion of informed consent lay in the judicial understanding of the three essential elements of consent to contractual relations originally specified by Ballow, who said that consent must be "an act of reason" involving "deliberation" with the "the mind weighing as in balance the good and evil on either side." [FN152] Indeed in Canterbury v. Spence, the court noted that "one of the difficulties with analysis in terms of 'informed consent' is its tendency to imply that what is decisive is the degree of the patient's comprehension." [FN153] Both Ballow's definition and the decision in Canterbury emphasize the consenting person's cognitive capacity. In today's parlance, consent to medical treatment has to be "an act of reason" in the sense that the consenting person must be shown to have realized that he or she is being asked to make a decision about medical treatment, has understood the information relevant to making this decision, and appreciates how this information would apply to his or her current situation. [FN154]

*26 B. The Influence of the Philosophical Writings of John Stuart Mill

The Blackstonian principle of the sacredness of the human body helped to extend the focus of the tort of battery from the inviolability of public peace, in which an individual was seen as a component of wider societal structure, to encompass the principle of the right to personal inviolability. However, Blackstone still looked at an individual and the right to personal integrity from the perspective of the communitarian interest of social harmony in the public sphere. Although the principle of personal inviolability or sacredness emphasized the right to be free from physical interference, it did not, automatically, entail the right to personal autonomy. It was philosophers like John Locke, Charles Montesquieu and John Stuart Mill who helped to invert the viewpoint by introducing the notion of personal liberty based upon delimitation of the power of the state as an expression of communitarian interests in relation to the individual. [FN155]
In his influential essay On Liberty, Mill argued that individuals should be amenable to society and its laws only when their conduct is based on choices that impinge on or concern others. "The only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant." Mill argued that society has full jurisdiction when an adult person's conduct is "other-regarding," that is, when the person's decisions affect prejudicially the interests of others. When the individual's conduct is "self-regarding" in the sense that it affects the interests of no person besides himself or herself--the individual's freedom to make the choice ought to be absolute because "over himself, over his own body and mind, the individual is sovereign." When the person's conduct has an effect upon the interests of other adults of "ordinary understanding," he or she must seek their "free, voluntary and undeceived consent." In all such cases, according to Mill, "there should be perfect freedom, legal and social, to do the action and stand the consequences." 

John Stuart Mill's doctrine that each individual "is the proper guardian of his own health, whether bodily, or mental or spiritual," has to be read in the context of his discussion of legitimacy of the power of the state. Mill explained that the only legitimate power of the state was that derived from the needs of individuals. The individuals, as he and other philosophers and essayists of that era saw them, seem to have been endowed with the characteristics of an English gentlemen--they were financially independent, rational, and mature. Mill emphasized that his doctrine of individual liberty was "meant to apply only to human beings in the maturity of their faculties," as distinct from those who are still in a state to require being taken care of by others, [and who] must be protected against their own actions as well as against external injury. For the same reason, we may leave out of consideration those backward states of society in which the race itself may be considered as its nonage.

Hence, the individual sovereignty was not a natural right of all human beings, rather it applied only to certain mature individuals who had the ability to exercise their "higher faculties," and who valued personal freedom to conduct their affairs with other individuals through voluntary agreements based on cooperation, consent, and contract, and without the interference of the state. Such individuals were the exemplars of a "person most interested in his own well-being" and it was to them that Mill accorded the absolute right to decide what to do "with his life for his own benefit." From the jurisprudential point of view, the notion that the individual alone--rather than society as an institution--has the right to make decisions concerning personal well-being was radical, because it implied that such decisions ought to be accorded legal recognition and protection. Traditionally, the only explicit right of refusal protected by law was the right of refusal by proprietors to part with or to allow strangers to interfere with their proprietary interests without lawful authorization. The implication of Mill's philosophy was that an individual had a personal proprietorship over his or her body and the consequent right to refuse beneficial interference in matters relating to personal well-being:

He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right. There are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him, or visiting him any evil, in case he do otherwise.
Mill's idea that the individual has an unqualified right to refuse beneficial interference in matters relating to personal well-being appears not to have been based on the principle that all individuals have a natural right to personal liberty. Rather, it was grounded in the utilitarian principle that unless individuals are left free from social pressure when they decide on matters that concern their private interests, including their own well-being, society may find it more difficult to achieve the ends for which it exists. [FN170] This is a quintessential consequentialist position whereby the choice of the right to appropriate action is determined by the desirability or appropriateness of its consequences.

The utilitarian societal aims and ends espoused by Mill were formulated at the turn of the 19th century by Jeremy Bentham, a close friend of John Stuart's father. Bentham's utilitarian doctrine was founded upon three principles, the first of which states that all human efforts as an organized society should be aimed at maximizing happiness and minimizing suffering in the world. The second principle, known as the hedonistic principle, defines the happiness of sentient human beings as the pleasure, or the absence of pain, and suffering as pain, or the absence of pleasure. [FN171] According to the third principle, the principle of impartiality, pleasures and pains of all sentient beings ought to be taken into consideration when decisions are made. In relation to the actual decision-making process, strict utilitarian philosophy does not permit any favoritism or privileges based upon mutual feelings, family relationships, or shared nationalities. [FN172]

Mill conceived personal liberty in terms of the classical freedom of action, liberum arbitrium—the freedom of choice between two or more desirable objects or ways of conduct. The notion of liberum arbitrium is predicated upon choice between things equally possible and available to us in statu nascendi as mere potentialities. [FN173] Actions can be justified only in terms of the outcome that would lead to the greatest utility in the sense of satisfaction or happiness. The relevant choice may be between pain and pleasure or suffering and well-being but it would always be in the context of survival—death is final, and does not involve any potentiality. For example, St. Augustine (354–430) in De Libero Arbitrio, [FN174] argued that those who believe they chose non-being when they commit suicide are in error because they chose a form of being that will come about one day anyhow, and they chose peace that can exist only as a form or aspect of being. [FN175] Centuries later, Immanuel Kant in the essay On Suicide wrote that "man's freedom cannot subsist except on condition which is immutable. This condition is that man not use his freedom against himself to his destruction." [FN176]

Whereas the first principle of utilitarianism is vital to the understanding of Mill's philosophical doctrine of personal liberty, the second and third principles of Benthamite utilitarianism have profoundly influenced modern judicial approaches to consent and refusal as legal concepts.

III. THE LAW OF CONSENT IN THE UNITED STATES IN THE FIRST TWO DECADES OF THE 20TH CENTURY

John Stuart Mill's philosophical ideas of personal liberty involving the individual's absolute right to decide what to do "with his life for his own benefit" were reflected in judgments delivered in two cases in the United States. In the 1905 case of Pratt v. Davis, [FN177] a husband placed his wife, Mrs. Davis, in a sanatorium for treatment for epilepsy. The defendant physician found that Mrs. Davis' "uterus was contracted and lacerated, and that the lower portion of the rectum was diseased." [FN178] He operated for "these difficulties." The patient did not improve, and some 10 weeks later...
she was returned to the sanatorium, where the physician performed a hysterectomy operation upon her. This operation was performed without the prior consent of Mrs. Davis or her husband. [FN179] The following extract from the physician's testimony is quoted in the judgment: "I worked her deliberately and systematically, taking chances which she did not realize the full aspect of, deliberately and calmly deceiving the woman; that is I did not tell her the whole truth." [FN180]

The defense argued that the patient was incompetent to grant consent because she suffered from epilepsy, and that a patient who consults a medical practitioner "gives him implied license to do whatever in the exercise *30 of his judgment may be necessary." [FN181] The judges rejected both arguments, and found that the defendant by acting without consent was liable in trespass. The case before the appellate court was reported in the Chicago Legal News in the following way:

Under a free government at least, the free citizen's first and greatest right, which underlies all others--the right to the inviolability of his person, in other words, his right to himself--is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon, however skilful [sic] or eminent, who has been asked to examine, diagnose, advise and prescribe (which are at least necessary first steps in treatment and care), to violate without permission the bodily integrity of his patient by a major or capital operation, placing him under an anaesthetic for that purpose, and operating on him without his consent and knowledge. [FN182]

The Supreme Court of Minnesota cited the above passage with approval when in 1905 it decided the case of Mohr v. Williams. [FN183] In this case, the patient, Anna Mohr, consented to have an operation performed on her right ear. In the course of the procedure, the treating physician decided that it was the patient's left ear that needed the surgery. The physician's nonconsensual operation on Ms. Mohr's left ear resulted in serious impairment of her hearing in that ear. She sued the physician for battery. The court affirmed the jury's award of $14,322.50 in damages, holding that the medical practitioner should have obtained Ms. Mohr's express consent before operating on her left ear. In the context of this ruling, the court referred to a passage from section 375 of 1 Kinkead on Torts, which articulated the position of the law in relation to consent.

The patient must be the final arbiter as to whether he will take his chances with the operation, or take his chances of living without it. Such is the natural right of every individual, which the law recognizes as the legal one. Consent, therefore, of an individual must be either expressly or impliedly given before a surgeon may have the right to operate. [FN184]

The court considered two exceptions to the rule that there must be an express consent to medical treatment. [FN185] Under the first exception, the law may imply consent in circumstances where a person is injured to the extent of being rendered unconscious and the injuries require prompt medical attention. Under these conditions, "a physician . . . would be justified in applying such medical or surgical treatment as might reasonably be necessary *31 for the preservation of the injured person's life or limb." [FN186] The second exception is really a variation of the first--when in the course of an operation to which the patient had consented, "the physician should discover conditions not anticipated before the operation was commenced, and which, if not removed, would endanger the life or health of the patient, he would, though no express consent was obtained or given, be justified in extending the operation to remove and overcome them." [FN187]

In 1913, the Civil Court of Appeals of Texas in Rishworth v. Moss [FN188] consolidated these two exceptions into a general rule when it stated that "there must
be consent in every case, except in an emergency when the delay to obtain consent would endanger the life or health of the patient." [FN189] In subsequent American cases, as well as in Canada, the United Kingdom, and Australia, the courts upheld the rule that unless the circumstances of emergency apply, a medical or surgical procedure that goes beyond the scope of a patient's express consent should be regarded as trespass, even when there was no evidence of an express prohibition. [FN190]

The legal justification for the emergency exception to the law of consent when applied to unconscious patients has changed from that of implied consent to the principle of necessity--the medical intervention must be shown to have been necessary "for the protection of the plaintiff's health and possibly his life." [FN191] The doctrine of necessity, as an exception to the law of consent, allows for provision of nonvoluntary therapy, in circumstances when the patient is not in a position to have or to express any views on the proposed clinical management. [FN192] This doctrine also applies to patients who are incapable of giving consent by reason of minority, and persons whose state of mind is such as to render their apparent consent invalid. [FN193]

The common-law doctrine of necessity was developed at the time when palliation was not regarded as an important aspect of medical care, and the study of pain relief was not very well advanced. Pain and suffering were accepted as part and parcel of the human condition--one was born in pain, lived in pain, and was expected to die in pain. Modern medicine understands (or ought to understand) that the experience of pain is detrimental to the patient's physical welfare and need not be endured. The aim of multi-modal pain management is to achieve satisfactory pain relief through the administration of adequate dosage and timing of analgesics (including long-acting oral preparations of morphine), palliative radiotherapy, chemotherapy, surgery, hormone therapy, anesthetic and neurosurgical techniques, physical treatment, and psychological support for the patient and his or her family. [FN194] Yet, palliative medical therapy would not come within the ambit of the defense of necessity because its aim is to prevent harm to the patient's quality of life rather than to protect the patient's life or health in the strict sense.

The facts in both the Pratt case and the Williams case, involved absence of consent to the particular treatment, rather than an explicit refusal thereof. In the 1913 case of Rolater v. Strain, [FN195] Mattie Inez Strain consented to an operation to drain an infection that developed after she stepped upon a nail which penetrated the big toe of her right foot. In the course of an operation that was performed under an anesthetic, the physician removed the sesamoid bone from her toe. Ms. Strain sued the medical practitioner in trespass, claiming that there was an agreement between them that "no bones should be removed." [FN196] She was awarded $1000. On appeal, the court upheld the patient's right to refuse certain procedures, and the physician's duty to act within the strict limits imposed by the ambit of consent when it is granted. The problem with the Rolater decision, however, is that the Supreme Court of Oklahoma misapplied this jurisprudential principle to the facts before it. The court seemed to persist in a belief that sesamoid bones are an integral part of the human anatomy, [FN197] when in fact--as the defendant physician rightly pointed out--they are nodules of bone that may be found in certain tendons where they rub over bony surface. [FN198] The removal of the nodules would have been necessary if they prevented proper drainage of the pus.

When interpreted literally, the principle that physicians will be liable for trespass unless they act within strict limits of the patient's consent, or unless they can avail
themselves of the narrow defense of necessity, [FN199] may lead to absurd results, as illustrated by one recent English case [FN200] in which a consultant anesthetist was found guilty of an assault (battery) by a suppository. The patient, before having four teeth extracted in a dental clinic, was provided with an explanation about the nature and effects of general anesthesia, but not about procedures that may be undertaken to relieve postoperative pain. She gave her consent to general anesthesia verbally and by implication. [FN201] While the patient was under the general anesthetic, the anesthetist inserted a diclofenac suppository for postoperative pain. [FN202] This was done in the presence of the dental surgeon and two female nurses; the patient was informed about the procedure when she regained consciousness. The anesthetist was found guilty of an assault and serious professional misconduct by the professional conduct committee of the General Medical Council, [FN203] on the grounds that while carrying out the pain-relieving procedure he "inserted the said substance diclofenac suppository without the patient's prior valid consent and thus assaulted her." [FN204] It is arguable that medical contact, which is beneficial to the patient but which is unauthorized due to the physician's genuine mistake as to the ambit of the patient's consent, ought not to be treated as battery with its semi-criminal implications. [FN205]

The preoccupation with the ambit of the patient's consent predates the jurisprudence of self-determination as a principle of tort, and has at its core the old contractual notion of consent as "an outcome of consenting minds" of the contracting parties. [FN206] For it was only in 1914 that the idea of a patient's right to self-determination was expressly introduced into the common law. The case was Schloendorff v. Society of New York Hospital, [FN207] and it concerned a surgeon who removed a fibroid tumor in circumstances where the patient had consented to an abdominal examination under anesthesia, but had specifically requested "no operation." The issue before the court was not battery, but the defendant hospital's liability for torts committed by surgeons while using its facilities. In the course of his opinion, Judge Benjamin Cardozo made the often quoted observation that: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." [FN208] This statement has an important place in the modern jurisprudence--it is relied upon as the basis for the doctrine that the person's right to refuse medical treatment should constitute an absolute personal interest.

The transposition of a utilitarian philosophical idea regarding political rights and commercial freedoms of an individual vis-à-vis the power of a state into the context of individual death-choices in the clinical setting, was filtered through the jurisprudential theory of rights propounded by Ronald Dworkin in a series of articles published in the 1960s and 1970s, the most important of which were collected in 1977 under the title Taking Rights Seriously. [FN209] In his analysis of legal standards that guide the judicial decision-making process, Dworkin made a distinction between policies and principles whereby "principles are propositions that describe rights; policies are propositions that describe goals." [FN210] Policies set out collective community goals, such as advancement or protection of political aims, economic efficiency, or social welfare. [FN211] Principles are to be observed because they embody the requirements of justice or fairness or some other dimension of morality, which respect or secure some individual or group right.

Dworkin contended that in civil cases, judicial determinations characteristically are, and should be, generated by principle not policy; and that adjudication of what
legal rights people have should be made in the light of an overall political theory that recognizes moral-political background rights (rights that provide a justification for a political decision by the society) as well as those concrete rights against fellow citizens already demarcated by law. Though not without its critics, Dwarkin's theory of rights, in particular, the notion that individual rights are based on two fundamental values--human dignity and political equality--was in harmony with the ideology of the then growing movement of consumerism. Dwarkin's emphasis on self as the central tenet of societal values, and the consequent notion of rights that are exclusively centered on the individual, exerted profound influence upon the legal theory and practice in all common-law countries.

IV. THE SANCTITY OF LIFE AND THE SANCTITY OF INDIVIDUAL SELF-DETERMINATION AS COMPETING LEGAL VALUES

Blackstone's principle regarding the absolute right to personal security was predicated upon a more comprehensive principle of sanctity of life--in the sense of inviolability--that he considered fundamental to a civilized society. After the Second World War, this principle was embodied in Article 3 of the Universal Declaration of Human Rights. Adopted by the General Assembly of the United Nations in 1948, it declares that "[e]veryone has the right to life, liberty and security of person." In Article 6 of the International Covenant of Civil and Political Rights (1966), the principle of sanctity of life has been interpreted as a right not to be deprived of life, except on such grounds as are established by law and consistent with principles of fundamental justice.

The principle of the sanctity of life is common to medicine and to law. In medicine, this principle forms the basis for the prohibition against medically assisted suicide in the Hippocratic Oath. In law, the principle of sanctity of life has been expressed in the following way:

Life and the concept of life, represents a deep-rooted value immanent in our society. Its preservation is a fundamental humanitarian precept providing an ideal which is not only of inherent merit in commanding respect for the worth and dignity of the individual but also exemplifies the finer virtues which are the mark of a civilized order.

At common law, the principle of the sanctity of human life has private and public law aspects. In public law, it has been interpreted by the courts to mean that the state has an interest in the preservation of human life. The protection of life remains a primary function of criminal law, and underlies the state's interest in preventing suicide. The principle of the sanctity of human life also lies at the core of the jurisprudential argument against capital punishment. In private law, the principle is manifested through the tort of battery.

The shift in the hierarchy of values that underpin the tort of battery, namely, from the sanctity of human life, to the sanctity of the human body, to the more recent value of the sanctity of individual self-determination, has been gradual. Neither the Schloendorff case, nor any prior case in which the issue of a patient's right to refuse certain medical procedures has been litigated and affirmed by the courts involved refusal of life-saving treatment. In fact, it appears that until Schloendorff, the courts still regarded the legal principle of the inviolability of the human body as based essentially upon the communitarian interest in the inviolability of human life. The common point in judgments holding that defendant medical practitioners should be liable for disregarding their patients' instructions, was that such conduct was detrimental to the patients' well-being in the Millsian sense. The approach of the
judiciary was in sympathy with the notion that the individual has an unqualified right to refuse beneficial interference in matters connected with his or her personal well-being as a sentient being. This approach excluded death-choices and self-annihilation.

The issue of refusal of therapeutic treatment, when the consequence of the person's choice would bring about death rather than survival, did not arise as a medical legal issue until medicine perfected life-saving and life-sustaining treatment. A procedural difference has emerged as a result of litigation involving the right to refuse life-saving or life-sustaining medical treatment. As noted above, the law of consent focuses on the presence or absence of a valid consent. In trespass, consent can be vitiated by duress, trickery, withholding of information in bad faith, or fraud; [FN218] therefore, the legal analysis is focused on the past conduct of the defendant-physician. So long as refusal was considered to be merely the obverse of consent for the purposes of establishing whether or not the defendant's conduct should be regarded as wrongful, cases were litigated only after the allegedly nonconsensual conduct had occurred.

Once the refusal of medical treatment came to be regarded as a separate right, plaintiff-patients began to ask the courts for injunctions and declarations to prevent interference with their choice to refuse treatment, including life-saving procedures. Hence, the law of refusal concerns proposed conduct or events, and it tends to focus on the person refusing the life-saving or life-sustaining treatment before it is to be administered. Moreover, because *37 injunctions and declarations are equitable remedies, the courts asked to grant this kind of relief should be guided not only by the common law but also by the principles of equity.

The seminal cases through which the law of refusal of medical treatment developed concerned the refusal of life-saving blood transfusions by Jehovah's Witnesses. The first successful blood transfusion for therapeutic purposes was carried out by James Blundell in 1829 at Guy's Hospital in London. However, it was only during the Second World War that blood transfusion became a common practice in obstetrics. [FN219] Jehovah's Witnesses are prohibited by the tenets of their religion to receive blood transfusions. Application of President & Directors of Georgetown College, Inc. [FN220] is the leading case on this issue. There, a 25-year-old woman, Jesse E. Jones, who lost approximately two-thirds of her total blood volume due to a ruptured ulcer, was brought to a District of Columbia hospital for emergency care in September of 1963. The attending physicians were of the opinion that the patient would die unless blood transfusions were administered. The patient and her husband were Jehovah's Witnesses and rejected this treatment option. Attorneys for the hospital initially sought a judicial order authorizing a series of blood transfusions and overruling the woman's right to refuse them. When this application was turned down, the attorneys applied to the Court of Appeals for the District of Columbia for an appropriate writ.

During the hearing at the bedside, Mrs. Jones and her husband indicated that while they objected to the blood transfusions on religious grounds, should the court order such procedure, they would not feel morally responsible. Justice Skelly Wright indicated four factors that persuaded him to issue an order authorizing the transfusions. First, the patient was the mother of a seven-month-old child. Consequently, the state had an interest in preserving Mrs. Jones' life; it also had an interest in preventing the abandonment of the child by allowing the mother to die. [FN221] Second, Justice Wright indicated that Mrs. Jones' religious beliefs were not designed to cause her death: such a result would be only an unfortunate repercussion of these beliefs. By coming to the hospital for treatment, the patient
indicated a desire to live. The third factor was a jurisprudential conundrum of whether a patient who exercises the right to refuse life-saving treatment is thereby placing the hospital and the medical personnel in a position of civil and criminal liability for either going ahead with nonconsensual treatment or allowing the patient to die. The judge did not find clear authority for the patient's right to restrict the kind of treatment she could receive to the point that death occurred. Justice Wright suggested that the fourth factor was decisive—the life of the patient hung in the balance. Unless he ordered the transfusion "to preserve the status quo," death would have mooted the entire problem. Rather than not acting, only to learn subsequently that the law required the transfusion to be ordered, the judge erred on the side of life. Each of the four factors discussed by Justice Wright for determining the existence of the right to refuse life-saving treatment has had a jurisprudential sequelae that will be analyzed in the context of subsequent developments.

A. The Interests of the State in Preserving Life and the "Right to Die"

The nature of the balance between the interests of the state and the interest of a patient in exercising the right of self-determination through refusal of life-saving treatment has been considered by United States courts primarily from the perspective of constitutional law. Most of the early cases concerned patients who refused medical treatment forbidden by their religious beliefs, and were argued on the basis of constitutional implications of the first amendment to the United States Constitution as well as the common-law right to self-determination.

In his opinion on the denial of rehearing in Application of President & Directors of Georgetown College, Circuit Judge Warren Burger (as he then was) relied on the dissenting opinion of Justice Brandeis in Olmstead v. United States, who considered that the fourth amendment to the United States Constitution endeavored to protect "Americans in their beliefs, their thoughts, their emotions and their sensations." It thus "conferred, as against the Government, the right to be left alone--the most comprehensive of rights and the right most valued by civilized man." In a remarkable exercise of mind-reading, Judge Burger determined that nothing in this utterance suggests that Justice Brandeis thought an individual possessed these rights only as to sensible beliefs, valid thoughts, reasonable emotions, or well-founded sensations. I suggest he intended to include a great many foolish, unreasonable and even absurd ideas which do not conform, such as refusing medical treatment even at great risk.

Generally, in the 1970s, cases that involved legal issues associated with the withdrawal of life-sustaining treatment from incompetent patients had at their core the existence of the constitutional right to refuse life-saving or life-sustaining treatment. The incompetent patient's "right" to have life-sustaining treatment withheld or withdrawn was initially interpreted by United States courts as being based on the common-law right to informed consent, "or on both the common-law right and a constitutional privacy right." Although the United States Constitution does not explicitly refer to the right to personal privacy, the courts have found "the unwritten constitutional right of privacy to exist in the penumbra of specific guarantees of the Bill of Rights." Subsequently, in the Cruzan case, the United States Supreme Court considered that the "right to die" through refusal of life-sustaining procedures—if it exists—is based not on the right of personal privacy but rather on the "liberty
interest" delineated in the fourteenth amendment to the United States Constitution. Section 1 of the fourteenth amendment to the United States Constitution provides that no State shall "deprive any person of life, liberty, or property, without due process of law." The issue before the Supreme Court was whether the fourteenth amendment prohibited the state from requiring clear and convincing evidence of the incompetent person's desire to withdraw or withhold life-sustaining treatment.

Hence, the judicial process employed in these cases entailed balancing state interests against the constitutional rights of the individual. In the case of Superintendent of Belchertown State School v. Saikewicz, [FN236] which involved the application to sanction the withholding of chemotherapy from a profoundly retarded 67-year-old leukemia patient, the Supreme Judicial Court of Massachusetts ruled that four state interests were implicated: (1) the preservation of human life; [FN237] (2) the protection of innocent third parties who *40 may be adversely affected by the death of the person seeking to exercise his or her "right to die"; (3) the prevention of suicide; and (4) the maintenance of the ethical integrity of the medical profession, including the right of the physician to administer medical treatment to the best of his or her judgment. [FN238] In Saikewicz, the court recognized the interest in preservation of human life as paramount and noted that it was greatest when the affliction was curable. [FN239]

In the United States, the issue of the right to refuse life-saving treatment tends to be grounded as much in the public constitutional law as in the private law of trespass to person. [FN240] In Australia and the United Kingdom, neither the interests of the state, as identified by the Supreme Court of the United States in Saikewicz and Cruzan, including the interest in preservation of life, nor the "liberty interests" of the individual to refuse life-saving treatment have a constitutional foundation. They are grounded in the common law of battery. [FN241]

Building on Judge Cardozo's statement that "every human being of adult years and sound mind has a right to determine what shall be done with his own body," modern common-law jurisprudence has elevated the principle of inviolability of negative individual decisions regarding one's body above that of the general principle of the sanctity of life. [FN242] This is because the principle of inviolability of the human body that is seen merely as an expression of the individual interest in personal self-determination, involves, by implication, the right to a death-choice manifested through refusal of life-saving treatment.

In 1986, the California Court of Appeal, in Bouvia v. Superior Court, [FN243] affirmed this doctrine by interpreting the statement of Judge Cardozo as meaning that a person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to medical treatment. It follows that such a patient has the right to refuse any medical treatment even that which may save or prolong her life. [FN244]

In England, the person's legal right to make a death-choice was succinctly expressed by Lord Goff of Chieveley in the case of Airedale NHS Trust v. *41 Bland, [FN245] where he stated that "the principle of the sanctity of human life must yield to the principle of self-determination." [FN246] Thus, the locus of the modern tort of battery has shifted from the sanctity of life to the sanctity of personal choices in relation to one's body and existence.

B. Religious Conviction and the Issue of "Sound Mind" as a Criterion of Decisional Competence
In the Application of President & Directors of Georgetown College, [FN247] Justice Wright's decision took into account the patient's views and religious convictions. [FN248] Justice Wright noted that Mrs. Jones was a committed Jehovah's Witness--a person whose religious beliefs compelled her to refuse life-saving blood transfusions--but who did not want to die. Her refusal was neither unexpected nor spontaneous. She was an adult who knew about, considered, and accepted the consequences of adhering to the tenets of her religion well before the circumstances that necessitated the blood transfusions arose. As such, her decision fulfilled the three criteria for valid consent as defined by Henry Ballow--it was "an act of reason" and "deliberation" by way of balancing "the good and evil on either side." [FN249] She also appeared to fulfill the medical requirements of competence, which include the capacity for understanding and communication, the capacity for reasoning and deliberation, and a stable set of values or a conception of what is bad and good. [FN250] In law, these capacities are subsumed under the legal criterion of "sound mind." The law uses the concept of sound mind to determine decision-making capacity--whether or not the person is, or was, capable of making a decision that ought to be binding on others.

The phrase "sound mind" is not a medical term. The expression denotes a strictly legal concept of competence, which traditionally refers solely to intellectual capacity. The law presumes an adult person to be competent unless the person is shown to be unable to carry out certain mental tasks. Competence, in the sense of cognitive ability to make a contract, to plead, to make a will, to vote in elections or to consent to treatment, is a legal concept and can be determined only by a judge or other duly constituted legal authority, though a psychiatrist or a psychologist may be *42 called in to assist in determining the standard of the person's competence. [FN251]

Although there is no specific case-law definition of "sound mind" for the purposes of the civil law of trespass, this concept has been negatively defined under testamentary law. In the case of Banks v. Goodfellow, [FN252] a legally competent person was described by Sir Alexander Cockburn CJ in the following way:

"To the due exercise of a power . . . involving moral responsibility, the possession of the intellectual and moral faculties common to our nature should be insisted on as an indispensable condition. It is essential to the exercise of such a power that a testator shall understand the nature of the act and its effects; shall understand the extent of the property of which he is disposing; shall be able to comprehend and appreciate the claims to which he ought to give effect; and, with the view to the latter object, that no disorder of his mind shall poison his affections, pervert his sense of right, or prevent the exercise of his natural faculties--that no insane delusion shall influence his will in disposing of his property and bring about a disposal of it which, if the mind had been sound, would not have been made." [FN253] In stressing the importance of the disposer's "natural faculties"--in the sense of his or her cognitive capacity--as an "indispensable" element of "sound mind," [FN254] Cockburn CJ was echoing the view of John Stuart Mill when he insisted that the doctrine of individual liberty was "meant to apply only to human beings in the maturity of their faculties." [FN255]

The language used in the judgment is open to very broad interpretation. It is possible to infer from it that when determining the decision-making competence of any individual, the court may take into consideration any psychiatric condition that may lead to an affective disorder, [FN256] making him or her unable to understand the moral difference between right and wrong, lead to serious cognitive impairment, or produce a psychotic state. However, in Banks, the Court of Queen's Bench chose to
interpret the criteria of "sound mind" very narrowly. In this case, the testator was convinced that he was pursued and molested by devils or evil spirits. Nevertheless, he was capable of looking after his financial affairs, and had given clear and rational instructions for his will, which left the greater part of his fortune to the niece who had looked after him. The court held that the will was valid. For, although the testator was suffering from an insane delusion, it did not influence his testamentary dispositions, because according to Cockburn CJ: "Though mental power may be reduced below the ordinary standard, yet if there be sufficient intelligence to understand and appreciate the testamentary act in its different bearings, the power to make a will remains." [FN257]

Thus, the juridical test for the purposes of civil law of a person's mental competence--whether or not he or she is of sound mind--is based on the cognitive criteria that measure the person's intellectual capacity to know, including the capacity to understand, weigh, and consider the nature of the proposed course of action. [FN259] For the purposes of decisional competence, the presumption of sound mind may be negated when the "disorder of the mind" (1) poisons the person's affections; (2) perverts his or her sense of right; (3) prevents the exercise of the person's natural faculties; or (4) where insane delusion influences the person's will.

The test of legal competence as set out in Banks v. Goodfellow has been criticized, particularly its reference to the standard of "insane delusion." [FN260] Yet, even this phrase has been judicially re-defined in terms of cognitive capacity:

Although made in the light of then existing medical knowledge, his Lordship's statement does not appear to differ, in substance, from the latter-day psychiatrist's test of what is a "delusion," that is, that it is not capable of rational explanation or amenable to reason, and that it is not explicable by reference to the subject person's education and culture. [FN261] In psychiatry, delusions, together with overvalued ideas, are classified under the broad category of impairment of mental function as abnormalities of thought content. Delusions can either be primary or secondary, they may be persecutory, grandiose, and alike, or may involve delusions of reference. In patients with schizophrenia, specific delusions of thought broadcasting, and delusions of influence may occur.

The definition of "sound mind" for the purposes of testamentary law must be considered in its context, and in particular, the principle that "the absolute and uncontrolled power of testamentary disposition conceded by law is founded on the assumption that a rational will is a better disposition than any that can be made by the law itself." [FN262] Nevertheless, the common law in general tends to focus upon the mechanism of the decision-making process rather than the decision itself. Once the procedural criteria as set by the law are satisfied, the actual decision--no matter how irrational and detrimental to the person's well-being--has to be respected. The reason provided by the common law for justifying the line drawn between the decision-making process and the decision is guided by the respect for the dignitary interests of an individual and his or her choices. [FN263] It would appear that such a complete separation of the decision-making process from the actual decision has its provenance in the dualistic theory of the mind and body dichotomy postulated by the 17th century French mathematician and philosopher René Descartes. [FN264]

Descartes identified mind, which he defined as a "res cogitans" (thinking thing) or cognition, with the immaterial soul. The experiences of cognition, perception, and emotion were considered by Descartes as the soul's immaterial reactions to some material movement in the blood or spirits of the bodily machine. The feelings,
whether of anger, grief, or joy, were not the cause but the consequence of prior material bodily actions and functions. [FN265] For the purposes of metaphysical inquiry, therefore, all issues related to mind and soul could be separated from the physical body and regarded as the domain of theologians and philosophers. The body, perceived as a complex mechanism with interacting solid and fluid parts, was the province of study by physiologists and physicians. The Cartesian separation of mind and body was challenged from a philosophical point of view already in the 17th century by Baruch Spinoza, who, in the Principles of Cartesian Philosophy, [FN266] and the posthumously published treatise *45 Ethics, [FN267] replaced the Cartesian theory of dualism with the concept of "psychological parallelism" according to which mind and body are inseparable. Mind and body form two aspects of the same entity--the living organism--which experiences its physiological processes psychologically as affects and thoughts. John Locke also repudiated the Cartesian interpretation of res cogitans, and the refusal by Descartes to endorse the old philosophical Latin maxim "nihil est in intellectu, quod non prius fuerit in sensu" (there is nothing in the realm of intellect (understanding) that did not originate from sensory perceptions). [FN268]

Toward the end of the 18th century in his Critique of Pure Reason [FN269] Immanuel Kant explored the nature of reason in the sense of cognition and the limits of the "knowing" process. [FN270] Having accepted that all knowledge begins with sensory experience, Kant analyzed how the "sensuous impressions"-- intuitions (Anschauung) antecedent to perception--are converted into an experience and then organized by intellect into knowledge. Kant pointed out that "although all our knowledge begins with experience, it does not follow that it arises from experience." [FN271] Sensory impressions were for Kant occasions for the activation in the mind of the rules of understanding-- identified with reason--which through the process of recognition and evaluation as well as categorization, helped the mind to conceptualize the original undifferentiated mass of sensory data into an "organized experience and the unity of consciousness." [FN272]

In 1858, Rudolf Virchow, in his book Cellular Pathology Based on Physiological and Pathological Histology, [FN273] demonstrated that the causes of the disease process lay in the disturbance of cellular pathology, and not in "invisible ethereal substances" as postulated by the medical followers of Descartes. Accordingly, Virchow suggested that disease could be explained best through changes in physiology and biochemistry of the organism, whereas illness was the subjective experience of suffering. [FN274] This approach to human homeostasis, which involves the physiological, sensory, and cognitive as well as affective functions, has been widely accepted by modern medicine. Nevertheless, it seems that the legacy of Cartesian separation of *46 mind and body still survives in the courts' analyses of the decision-making process and the decision itself.

It is arguable that the notion of the "sound mind" as legal standard based exclusively on the criterion of cognitive ability of the patient to understand what is being said to him or her, and to make an informed decision in an intellectual sense, is not the most suitable way of ascertaining that person's mental state in the context of a refusal of life-saving treatment, particularly when the decision is made during a medical crisis. [FN275] The English case of Re T [FN276] illustrates pressures that may impair the decision-making capacity of an adult patient in an emergency situation. Thirty-year-old Ms. T was injured in a car accident when she was 34 weeks pregnant. Though not a Jehovah's Witness herself, Ms. T was brought up by her divorced mother, a fervent member of the sect. The injured woman was admitted to a hospital, where, following diagnosis of pneumonia, she had to be given high doses of
antibiotics, oxygen, and pethidine (a narcotic analgesic). After she went into labor, Ms. T was transferred by an ambulance to the labor ward. By that time, Ms. T had had two private conversations with her mother, and subsequently informed the midwife and the physician about her opposition to blood transfusions. The obstetrician assured her that a cesarean section did not usually necessitate a transfusion and, in response to her inquiry, said that other, less effective, procedures also were available. As the physician was leaving, the midwife produced a hospital form of refusal of consent to blood transfusions, which Ms. T signed and the midwife countersigned. [FN277]

Following an emergency cesarean operation the child was stillborn. Ms. T's condition seriously deteriorated and she was transferred to an intensive care unit. The medical opinion was that Ms. T needed a blood transfusion. She was put on a ventilator and paralyzing medications were administered. Ms. T remained sedated, though in critical condition, while her father, supported by the father of the baby, applied to the court for a declaration that it would not be unlawful for the hospital to administer a blood transfusion in the absence of her consent. Judge Ward granted the declaration, and the appeal from the Official Solicitor as guardian ad litem for Ms. T was dismissed by the Court of Appeal. [FN278] The court said that at the *47 time she signed the hospital refusal of blood transfusion form, the patient was in considerable pain, she was suffering contractions in the first stage of labor, her consciousness was clouded by repeated doses of pethidine, and she was acting under the influence of her mother. In relation to the last factor, outside influences, that may compromise the voluntariness of the patient's decision to refuse life-saving treatment, Master of the Rolls, who delivered the leading judgment, pointed out that

[The real question in each case is: "Does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself?" When considering the effect of outside influences, two aspects can be of crucial importance. First, the strength of the will of the patient. One who is very tired, in pain or depressed will be much less able to resist having his will overcome than one who is rested, free from pain and cheerful. Second, the relationship of the "persuader" to the patient may be of crucial importance. The influence of parents on their children or of one spouse on the other can be, but is by no means necessarily, much stronger than would be the case in other relationships. [FN279]

There are a number of reasons why the legal criteria involving the decision-making capacity of seriously medically impaired persons, including those who refuse life-saving treatment, should be different from the traditional approach, which has been developed in relation to determining the validity of consent amongst those who are physically and emotionally well.

The common-law jurisprudence has adopted the third principle of utilitarianism—that of strict impartiality, which precludes from consideration such subjective factors as personal condition, feelings, the effects of kin-ship, and religious or nationality affiliations—as the touchstone against which all legal standards are traditionally measured. [FN280] Lord Mustill in Aire-dale NHS Trust v. Bland expressed this rule in the following terms:

If the patient is capable of making a decision on whether to permit treatment and decides not to permit it his choice must be obeyed, even if on any objective view it is contrary to his best interests. A doctor has no right to proceed in the face of objection, even if it is plain to all, including the patient, that adverse consequences and even death will or may ensure. [FN281]
Lord Mustill's analysis may be applicable without qualification to Mrs. Jones who, as a member of a particular religious congregation, had made a *considered choice to follow the precepts of her creed long before the actual circumstances that necessitated blood transfusion eventuated. [FN282] However, it is questionable whether such an unqualified rule should be equally applicable to death-choices through refusal of life-saving treatment made by the systemically ill, the febrile, the depressed, those who suffer from psychoses and other mental disorders. The ability of psychiatry to understand human decision-making process has come a long way since Ballow's analysis of the nature of consent and the criteria for determining "sound mind" as applied in Banks v. Goodfellow. The time has come for reappraisal of these legal concepts in the light of modern medicine.

Medicine, and in particular psychiatry, recognizes that such factors as the patient's personality, affective disorder, medications, external pressures and the setting, may impair clinical competency, leading to a refusal of treatment. Disease is frequently accompanied by stress and/or pain, productive of depression, that may impair the patient's ability to function competently in processing and understanding medical information and making treatment decisions. [FN283] The prevalence of severe depression among patients who are medically ill has been estimated as being between 10% and 20%, with a prevalence rate of twice that among geriatric patients and those who are severely medically ill. [FN284] Interviews in the form of psychological or psychiatric autopsy with surviving relatives of suicides have found that a very large proportion (between 50% and 100%) of the deceased had suffered a psychiatric disorder, particularly depressive illness, in the period immediately preceding the suicide. [FN285] Susan Sorenson observed that "the elderly, the emotionally stressed, and persons who lack stable connections with others appear to be the most frequent victims of suicide." [FN286]

The law presumes that every adult individual is cognitively competent to make all medical decisions until proven otherwise. [FN287] The case of In re *AC [FN288] is an example of the application of this legal rule. In this case, a 27-year-old patient, who was 25 weeks pregnant, and who had suffered from a variety of cancers since the age of 13, was admitted to the high-risk unit of the obstetrics department at George Washington University Hospital. The patient, Angela Carder, was diagnosed as being in a terminal stage of an inoperative tumor nearly filling her right lung. At the time the fetus reached 26 1/2 weeks of gestation, its chances of survival were deteriorating, due to the seriousness of Ms. Carder's physical condition. When asked if she still wanted the baby, her answer appeared to be "I don't know; I guess so." [FN289]

The hospital petitioned for an emergency hearing to be held at the hospital before a judge of the Superior Court of the District of Columbia. The hospital sought a declaration that the cesarean section could be carried out if the patient refused permission. The operation was not intended to save or prolong the mother's life, but to provide a slim possibility of the 50% to 60% chance of survival for the fetus. At the time of the hearing, the judge found that due to heavy sedation and intubation, it was not clear what the patient's wishes were. Nevertheless, he granted the declaration. The baby was born alive, but died within three hours. The patient died of cancer two days later. [FN290] The District of Columbia Court of Appeals vacated the primary decision. [FN291] The majority stated that "in virtually all cases," a pregnant woman has the right to decide what is to be done on behalf of herself and the fetus. [FN292] It is the duty of the court to determine the patient's competency, and, if the patient is found incompetent or otherwise unable to give an informed consent to the proposed
therapy, the judge must ascertain her wishes through the process of substituted
judgment based on all the evidence.

Medical studies published during the last decade have noted that cognitive
disorders are a frequent complication of cancer. [FN293] These studies show that
patients with advanced terminal cancer often experience repeated episodes of
cognitive failure [FN294] as recorded on the Mini-Mental State
Questionnaire, [FN295] a screening test used for cognitive assessment. [FN296] A study using the Abbreviated Mental Test Score (AMTS) and a semistructured
application of modified DSM III-R criteria for major depressive illness [FN297]
found that 34% out of 87 terminally ill cancer patients displayed significant cognitive
impairment. The principal determinants of cognitive impairment were age and
proximity to death.

Cognitive failure in patients with advanced cancer may be caused by medications,
sepsis, brain metastases, liver failure, renal failure, hypercalcemia, or hypoglycemia,
amongst other possible precipitants. However, in the study by Bruera and
colleagues, [FN298] no cause of cognitive failure could be established in 56% of
cancer patients. [FN299] The available data suggested that cognitive failure was
extremely frequent in patients with advanced cancer approximately 16 days before
death. [FN300] Therefore, it has been postulated that cognitive failure may be part of
an organic brain syndrome that represents the final stage in many dying
patients. [FN301]

There are only two findings that are open to a tribunal that utilizes the legal
standard of "sound mind" --competence and incompetence. Yet, there are many levels
of cognitive impairment. In an acute organic brain syndrome (delirium), the patient
develops a global impairment of cognitive functioning, which may be mild and hence
easy to overlook. In particular, mild delirium may not be recognized by the clinician if
it is associated with only a slight degree of "clouding of consciousness" (impaired
state of consciousness, which in severe delirium progresses to stupor or coma). Such
cognitive failure usually manifests itself as disorientation in relation to time, place,
and person. Its particular manifestations also include inability to sequence recent
events, odd and inconsistent behavior, irritability, and suspiciousness. A well-
developed syndrome may include such features as impaired concentration and
memory, together with reduced awareness of and responsiveness to the
environment. [FN302] The speech of a person suffering from acute cognitive failure
may be characterized by restriction of content, repetition, and perseveration. [FN303]

Perhaps the most important aspects of acute cognitive failure that need to be
considered when a patient is making vital life and death decisions in a clinical setting
are the changes that occur with respect to thought content and organic mood changes.
These changes may involve impoverishment of intellectual function manifesting itself
as concrete thinking--the inability to abstract the sense of what is said from its literal
meaning--as well as emotional liability, at times involving a sense of bewilderment
that may verge on fear or terror. In extreme cases of delirium, the patient may develop
delusions, as well as manifesting cognitive impairment and clouding of
consciousness.

In a recent study, Grisso and Appelbaum [FN304] have investigated decision-
making capacity among three groups of hospitalized patients: those with diagnoses of
schizophrenia, major depression and ischemic heart disease (angina pectoris), and an
equal cohort of community subjects matched on age, race, gender, education, and
occupation. Each subject was tested for the ability to (1) express a choice; (2) to
"understand the treatment discourse" in the sense of understanding information
relevant to the decision about treatment; (3) to appreciate the significance of his or her own situation of the information disclosed about the illness and possible treatments (perceptions of the disorder, nonacknowledgment of disorder); and (4) to manipulate the information rationally (or reason about it) in a manner that allows for making comparisons and weighing opinions. [FN305]

The study found that whereas only a few subjects were unable to express a choice, there were significant differences between the performance of the groups in relation to the three remaining measures. In particular, it is of concern that a substantial number of subjects who performed adequately on one measure revealed impaired performance on another. Thus, of the 72% of subjects with schizophrenia who performed adequately on the understanding measure, 24.1% had impaired performance on appreciation and 14.8% on reasoning. [FN306] When, in accordance with the legal standard for competency, all measures are compounded, 52% of subjects with schizophrenia would be considered as having impaired capacity to make treatment decisions. Comparable figures for the other groups were *52 23.9% for patients with major depression, 12.2% for the group with angina pectoris, and 4% for the three community comparison groups combined. [FN307]

The law needs to be more attuned to the reality of medical illness as understood by modern medicine, and to take into account the subtle distinctions in cognitive competency. Moreover, while separating the actual decision from the cognition-oriented decision-making process may have some merit, in cases where the choice of life-style is in issue, such separation is inappropriate when applied to cases where the choice is between life and death. The legal definition of "sound mind" would not exclude a person with a paranoid disorder, who insists that he or she does not suffer from the given condition, and is thus quite eager to declare that no treatment should be undertaken. Yet, as the Grisso and Appelbaum study illustrates, it is common in paranoid conditions for the person's cognitive functioning to remain intact. Such a person can appear to have a thorough understanding of the risks and benefits of the treatment, or of alternative treatments, without actually being able to interpret these data as relevant in the context of his or her own situation. [FN308] It has been claimed that persons suffering from paranoid conditions, [FN309] or from serious affective disorders, [FN310] "constitute the largest population of treatment refusers." [FN311]

In the case of Re T, [FN312] Lord Donaldson MR emphasized that the patient's right to choose death should be held paramount only after "a very careful examination of whether, and if so the way in which" [FN313] the patient was exercising that right. "In case of doubt, that doubt falls to be resolved in favour of preservation of life for if the individual is to override the public interest, he must do so in clear terms." [FN314] He expressed the rules pertaining to the patient's capacity to make legally binding choices concerning medical treatment in the following way:

(1) Prima facie every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death. Furthermore, it matters not whether the reasons for the refusal were rational or irrational, unknown or even non-existent. This is so, notwithstanding the very strong public interest in preserving the life and health of all citizens. However, the presumption of capacity to decide, which stems from the fact that the patient is an adult, is rebuttable. (2) An adult patient may be deprived of his capacity to decide by long-term mental incapacity . . . (3) If an adult patient did not have the capacity to decide at the time of the purported refusal and still does not have that capacity, it is the duty of the doctors to treat him in whatever way
they consider, in the exercise of clinical judgment, to be in his best interests. (4)

Doctors faced with a refusal of consent have to give very careful and detailed consideration to what was the patient's capacity to decide at the time when the decision was made. It may not be a case of capacity or no capacity. It may be a case of reduced capacity. What matters is whether at that time the patient's capacity was reduced below the level needed in the case of a refusal of that importance, for refusals can vary in importance. Some may involve a risk to life or of irreparable damage to health. Others may not. [FN315]

These rules apparently were applied by Thorpe J in the 1994 case of Re C (Adult: Refusal of Treatment), [FN316] when the High Court of England was asked to grant an injunction restraining the hospital from carrying out an amputation without the patient's express written consent. The case involved a 68-year-old man, Mr. C, who was an emigrant to England of Jamaican origin. His passage was paid for by a woman who left him five years after his arrival. A year later he accosted her at work and after an altercation stabbed her. Mr. C was sentenced to a seven-year term of imprisonment, but on being diagnosed as suffering from chronic paranoid schizophrenia, was transferred to a Broadmoor secure hospital. Over the years, he had been treated with medications and ECT. In 1994, Mr. C knocked his left foot in a shower and some three weeks later developed gangrene in that foot.

At a general hospital, the consultant surgeon told Mr. C that unless his leg was amputated below the knee, he would die within a very short time. His prognosis was that at best, Mr. C had a 15% chance of survival without amputation. Mr. C refused to consent to the amputation. However, he was persuaded to agree to a treatment with antibiotics, and then a debridement of the dead tissue under a general anesthetic. Mr. C said he would rather die with two feet than live with one. He expressed grandiose delusions of an international career in medicine during the course of which he had never lost a patient. He affirmed his complete confidence in his ability to survive his present trials aided by God, the "good doctors," and the "good nurses." [FN317]

Mr. C was seen by three psychiatrists, including Dr. Eastman, a lecturer and a senior consultant in psychiatry at St. George hospital, who explained that schizophrenia is an all-pervasive illness. Features present in Mr. C's case included grandiose and persecutory delusions as well as an incongruity of affect—Mr. C's words did not match the emotions which he *displayed. According to Dr. Eastman, although Mr. C appeared to understand the information about the possible treatments and their outcomes, he did not believe it, and so was unable to weigh the information provided to him, that is, to determine the risks and benefits involved in relation to his own condition. Dr. Eastman considered that Mr. C did not believe in the imminence of his death because of his mental illness. Dr. Eastman indicated that the ultimate conclusion should be reached "by weighing in the scales the preservation of life against the autonomy of the patient. If the patient's capacity to decide is unimpaired, autonomy weighs heavier, but the further capacity is reduced, the lighter the autonomy weighs." [FN318] The other two psychiatrists agreed with Dr. Eastman's assessment. However, Mr. Rutter, the consultant vascular surgeon, believed in "the sanctity of the individual choice, even if it be wrong" [FN319] and argued that the amputation should not be performed against the patient's wishes.

Thorpe J of the Family Division of the High Court of England, agreed with Mr. Rutter, and granted an injunction to prevent surgeons from operating on Mr. C's leg without his consent. The judge declared that the presumption in favor of Mr. C's right of self-determination had not been displaced, and his choice not to undergo the amputation had to be respected. In coming to his conclusion, Thorpe J used the legal
critterion of "sound mind," which disregards the patient's affective function, including
the presence of major functional disorders such as schizophrenia and depression.

There are also some psychopathological conditions in which the individual
manifests illness behavior considered to be "abnormal," that is, out of keeping with
the objective evidence of disease. [FN320] A person's illness behavior may be
characterized as "abnormal" in cases where there is

the persistence of an inappropriate or maladaptive mode of perceiving, evaluating
or acting in relation to one's own state of health, despite the fact that a doctor (or other
appropriate social agent) has offered an accurate and reasonably lucid explanation of
the nature of the illness and the appropriate course of management to be followed,
based on a thorough examination of all parameters of functioning, and taking into
account the individual's age, educational and sociocultural background. [FN321]

Abnormal illness behavior can take several forms of illness denial. [FN322]
Illness denial may be motivated by a conscious desire to obtain employment,
by guilt and shame, by fear of the stigma and discrimination associated with *55 psychiatric
symptomatology, or by hope to avoid feared therapies such as chemotherapy and
radiotherapy. Sometimes illness denial may have unconscious motivation, such as
neurotic noncompliance following myocardial infarction or refusal to accept
psychological diagnosis or treatment in the presence of neurotic illness, personality
disorder, or drug dependency syndromes. Persons suffering from psychotic
depression, manic states, and schizophrenic disorders often present with denial of
illness, including somatic pathology. Patients with neuropsychiatric syndromes, such as
Korsakoff's psychosis caused by alcohol abuse, also tend to present with
confabulatory reactions to illness. [FN323]

Subtle, or even overt, pressures by family, and sometimes by clinical personnel,
may impair the affective function of a patient and morbidly distort his or her view of
life leading to refusal of life-saving treatment. [FN324] Finally, on a sociocultural
level, it has been noted that the fundamental shift of traditional values from solicititude
and benevolence to patient autonomy and self-fulfilment has had the effect not only of
eroding community support for expensive long-term care, but also has affected the
self-esteem of the afflicted persons. [FN325] In this context, one may ponder whether
the advocacy of an unqualified right to refuse life-saving treatment is prompted as
much by belief in an inalienable right to self-determination as by other, less
benevolent, personal and communitarian interests.

The traditional state interest in preservation of life based upon the cost to the
community of supporting the family of a person who dies as a result of refusing
medical treatment has lost its cogency in the reality of health care economics in the
1990s. [FN326] For instance, in the United States, approximately 30% of the
Medicare budget is spent on medical treatment during the last year of its beneficiaries'
lives. [FN327] The cost of hospital care for an adult patient in a persistent vegetative
state for the first three months has been estimated at approximately $149,200, and the
costs of long-term care at a nursing facility tend to range from $126,000 to $180,000
per year. Annual cost of home care for children in a persistent vegetative state is
estimated at $129,000 for the first year, and $97,000 for subsequent years. [FN328]
While the *56 cost of care for the chronically ill is very high, [FN329] so is the
expense involved in the provision of certain drugs, [FN330] and such life-saving
treatment as heart, lung, and liver transplantations. [FN331] The resurgence of home
medical care has been accompanied by financial and emotional strains on the care
providers. [FN332]
Legislative efforts to facilitate patient refusal of treatment, by way of such instruments as living wills, advance directives, and their variations [FN333] is aimed at furthering the interest in self-determination. However, there is also an expectation that costs associated with end-of-life medical care will thereby be substantially contained. [FN334] The doctrine of the "human capital," which is one of the most influential determinants of the nature and the level of funding of the health care system by governments, measures the strictly economic costs of disease. [FN335] The aim of this method of evaluating the value of life is to "remind the society that the burdens of disease are borne not only by the sick but by all those who would benefit from the contribution to society that would be made if the patient were whole again," [FN336] or, alternatively, *57 savings that accrue to the health care system whenever a patient decides to refuse expensive medical treatment, or requests that his or her now "unproductive" life be terminated. [FN337] It is true that in the context of end-of-life management, provision of high quality palliative care is much more important to the welfare of patients and their families than the employment of life-sustaining "heroic medicine," when its aim merely is to prolong the biological existence of hopelessly ill patients at the cost of their increased suffering. This change in emphasis, however, should not be motivated by the economic concern to save scarce and expensive medical resources. Rather, provision of palliative care should be grounded in the deontological respect for human life regardless of a person's sex, age, creed, or physical or mental status, coupled with acknowledgment that death is an integral and inevitable part of life. [FN338]

Studies have demonstrated that patients, particularly those with serious injuries, such as spinal cord injury, tend to suffer from depression in the early stages of their treatment, which often manifests itself in an express wish to die. [FN339] This condition presumably would be compounded when such a patient is also a prisoner. It is imperative that in a civilized society, patients who are prisoners should enjoy rights to self-determination with respect to medical treatment that are no less valuable than those enjoyed by other patients. However, the determination as to whether these patients are truly competent to make life and death choices should not be made on the basis of normative principles, in disregard of their actual affective state and their legal status.

In the United States, in the case of Thor v. Superior Court of Solano County, [FN340] the Supreme Court of California quoted John Stuart Mill's statement that "over himself, over his own body and mind, the individual is *58 sovereign" [FN341] when it decided that Howard Andrews, a prisoner serving a 15-year-to-life sentence for murder, had the right to reject medical treatment, even if it meant that he would die. Andrews became quadriplegic as a result of a jump or a fall from a cell tier at California's Folsom Prison in 1991. At the medical facility at Vacaville, staff psychiatrists who examined Andrews found him "depressed about his quadriplegic condition but mentally competent to understand and appreciate his circumstances." [FN342] In its brief as an amicus curiae, the California Medical Association argued that the possible inadequacy of medical and other services in prison may compromise the voluntary and rational nature of an inmate's decision. Consequently, when a prisoner refuses life-saving medical treatment, there should be a mandatory judicial hearing to assess the impact of the prison environment on the prisoner's decision-making capacity. In rejecting this suggestion, the court took judicial notice of the presumption that the "medical facilities within prison walls meet the same professional standards as those without," [FN343] and of the "constitutional and administrative protections guaranteeing an inmate a proper treatment." [FN344]
The court ruled that a proposal for a mandatory judicial hearing "tends to denigrate the principle of personal autonomy, substituting a species of legal paternalism for the medical paternalism the concept of informed consent seeks to eschew," and declared that "'rationality' is for the patient to determine." [FN345]

The modern law has been so zealous to secure the individual a right to self-determination that it has lost sight of the wider humanitarian considerations and compassionate principles that play an important part in protecting the vulnerable, the depressed, and the disabled.

C. The Nature of Physician-Patient Relationship

Roscoe Pound pointed out that the legal tradition of common law displays a certain jurisprudential dichotomy. While it focuses upon an individual and zealously guards individual rights, it also tends to impose duties and liabilities upon those standing in certain relations as members of a class rather than upon individuals. [FN346]

The third factor considered by Justice Skelly Wright in Application of President & Directors of Georgetown College was the issue of competing autonomies—the individual autonomy of the patient and the professional autonomy of the attending physicians. The modern jurisprudence has yet to find a clear answer to the problem presented by patients who voluntarily *59 come to the hospital but who, once there, choose to exercise their right to refuse life-saving treatment, thereby placing the hospital and medical personnel in a position of potential legal liability for either going ahead with nonconsensual treatment or for allowing the patient to die. [FN347]

The physician-patient relationship as presented in Corpus Hippocraticum, or even in Percival's Medical Ethics, has undergone profound changes in the past 200 years. [FN348] In the Hippocratic tradition, the responsibility for making clinical treatment decisions was delegated to physicians in the belief that their clinical training, a degree of emotional detachment, and the ethical ideals expressed in the Hippocratic Oath, [FN349] would best qualify them to accurately diagnose and suggest treatment options that were in the best interests of each particular patient. [FN350] Nevertheless, with regard to the issue of consent, the traditional Hippocratic approach has been modified in accordance with modern social and cultural expectations. Physicians have come to realize that in the necessarily unequal physician-patient relationship, where the medical practitioner has expertise from which the patient hopes to benefit, seeking a consensual approach based upon an adequate disclosure of relevant information goes some way toward ameliorating the ethical dynamics of the relationship. Disclosure of treatment options and discussion of their respective advantages and disadvantages promotes the principle of non-maleficence (discussed below) without derogating from the clinical autonomy of the treating physician. This modified approach pre-supposes that, insofar as it is practicable, the role and duty of the physician is to work together with the patient toward the therapeutic goals they have arrived at in consultation.

In law, the relationship between patient and physician is today generally regarded as at least partly grounded in the law of contract. Thus, in the English case of Sidaway v. Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [FN351] while considering a patient's right to be informed, Lord Templeman observed that "the relationship between doctor and patient is contractual in origin, the doctor performing services in consideration for fees payable by the patient." This notion, though not entirely accurate, presupposes that for a fee, the patient gets the medical practitioner to "service" his or her health. Although unarticulated, the concept
of human health as a form of commodity, coupled with the 19th century's principle of freedom of contract, has been as much responsible for affording jurisprudential legitimacy to the doctrine that "every human being of adult years and sound mind has a right to determine what shall be done with his own body," as was the tort-based principle of bodily integrity. Contractual approach, centered as it is on the doctrine of consenting minds, can operate only in circumstances where the wishes of the consenting parties are known. Jurisprudential problems created by the underlying assumption about the contractual nature of the physician-patient relationship are evident in the inability of the law to develop a unified conceptual framework to deal with the issue of withholding or withdrawal of life-sustaining treatment from incompetent persons whose wishes in relation to medical treatment are unknown. The more jurisprudentially satisfactory resolution of this issue can be found within the covenantal model of the physician-patient relationship, based on the best interests standard.

Perhaps due to the perception of health as a commodity, some courts in the United States, Canada, and New Zealand have started to characterize the rights and obligations of medical practitioners and their patients as fiduciary. For instance, in the case of McInerny v. MacDonald the Supreme Court of Canada identified the relationship between the physician and the patient with "that which exists in equity between a parent and his child, a man and his wife, an attorney and his client, a confessor and his penitent, and a guardian and his ward" and classified it as "as a fiduciary or trust relationship." The court determined that the fiduciary nature of the relationship obligated the physician "to act with utmost good faith and loyalty and to hold information received from or about a patient in confidence." The characterization of the physician-patient relationship as fiduciary does not accord with the principles of equity. The fiduciary relationship of trust and confidence arises where one party to the relationship assumes the obligation to act in the other's proprietary interests. The adjective "confidential" in a trusting relationship is used to indicate the attribute of "trust and confidence." However, the term "confidential" is used in a different legal sense when it designates a relationship that is formed whenever one party imparts to another private or secret information in reliance upon the express or implied acceptance by the party in the position of a confidant that the communication is for a restricted purpose.

Indeed, in Sidaway v. Governors of Bethlem Royal Hospital, Dunn LJ, in the English Court of Appeal, said that the fiduciary rule "has been confined to cases involving disposition of property, and has never been applied to the nature of the duty which lies upon a doctor. . . . " On appeal, Lord Scarman also rejected the notion that the relationship between patient and physician is of a fiduciary character that would entitle the patient to relief in the event of a breach of fiduciary duty by the medical practitioner. Lord Scarman stated that

there is no comparison to be made between the relationship of doctor and patient with that of solicitor and client, trustee and cestui qui trust or the other relationships treated in equity as of a fiduciary character. Nevertheless, the relationship of doctor and patient is a very special one, the patient putting his health and his life in the doctor's hands. Following a thorough examination of the subject in Australia, the majority of the Court of Appeal of the New South Wales Supreme Court approved the reasoning in the judgment of Lord Scarman and rejected the labeling of the physician-patient relationship as fiduciary. Justice Mahoney pointed out that although
the law requires a doctor to act with the utmost good faith and loyalty to his patient and to hold information given to him by the patient in confidence. . . it is wrong to infer from such obligations that a more general relationship--trustee or fiduciary--exists. . . . A doctor is plainly not a trustee vis-a-vis his patient. [FN365]

Unless the physician holds in trust for the patient identifiable items of property, use of such terms as "fiduciary" or "trustee" does not represent accurate statement of the law and consequently "confuses rather than assists proper legal analysis of relationships and of what, in law, results from them." [FN366] To sum up, a physician patient relationship has some fiducial characteristics, yet, the essential element of a trusteeship over another person's property rights is missing. [FN367] Therefore, although the relationship between physician and patient is classified as "confidential" and one of dependence, these features alone do not transform it into a "fiduciary" or "trust relationship" as those terms are used in the law of equity. [FN368] It is more appropriate to use covenantal terminology when referring to a physician patient relationship.

D. Consent and Clinical Decision-Making

Agreement is an essential element of a covenantal relationship. Lord Donaldson MR originally defined the role of consent to medical treatment in the following way:

"Consent by itself creates no obligation to treat. It is merely a key which unlocks the door." [FN369] In a subsequent judgment he qualified this statement when he said:

"On reflection I regret my use in Re R of the keyholder analogy, because keys can lock as well as unlock. I now prefer the analogy of a legal 'flak jacket' which protects the doctor from claims by the litigious." [FN370]

Thus, in the case of In re J (A Minor), [FN371] the Court of Appeal said that neither a patient nor a court has any statutory or common-law right to insist that a particular treatment or intensive care be provided to the patient when such therapy is not medically indicated. [FN372] The case involved an 18-month-old child, J, who at the age of one month sustained serious head injuries that rendered him profoundly mentally and physically handicapped, suffering from microcephaly, cerebral palsy, cortical blindness, and severe epilepsy. He was considered unlikely to develop greatly beyond his present state and had an uncertain but shortened life expectancy. J's intermittent convulsive attacks required resuscitative treatment in the hospital, and in December of 1991, the consultant pediatrician considered that it was medically inappropriate to use mechanical ventilation procedures for any future resuscitation. Asked to determine whether artificial ventilation and other life-saving treatment should be administered to J, the Court of Appeal held that medical practitioners should not be required to treat patients in a manner contrary to their clinical judgment and professional duty.

In the leading judgment, Lord Donaldson MR presented the following analysis of this issue:

I have to say that I cannot at present conceive of any circumstances in which this would be other than an abuse of power as directly or indirectly requiring the practitioner to act contrary to the fundamental duty which he owes to the patient. This, subject to obtaining any necessary consent, is to treat the patient in accordance with his own best clinical judgment, notwithstanding that other practitioners who are not called upon to treat the patient may have formed a quite different judgment or that the court, acting on expert evidence, may disagree with him. [FN373]
Quoting from an earlier decision, [FN374] the judge explained the legal relationship between physicians and those who have the right to make decisions on behalf of incompetent patients in the following way:

No one can dictate the treatment to be given to the child--neither court, parents nor doctors. There are checks and balances. The doctors can recommend treatment A in preference to treatment B. They can also refuse to adopt treatment C on the grounds that it is medically contra-indicated or for some reason is a treatment which they could not conscientiously administer. The court or parents for their part can refuse to consent to treatment A or B or both, but cannot insist upon treatment C. [FN375]

Leggatt LJ noted that the Court of Appeal has not given to physicians any right they did not previously have by ruling that the medical staff should be free, subject to consent not being withdrawn, to treat patients in accordance with their best clinical judgment. The decision "has merely declined to deprive them [physicians] of a power which it is for them alone to exercise." [FN376] Although the judgments, and therefore the rules, were made with reference to the powers of guardians and courts making treatment decisions for incompetent patients, there is no reason why the same principle of professional autonomy should not apply within a physician-patient relationship when the patient is fully competent. The law sets a limit to the patient's right of self-determination by constraining the patient's capacity to request the kind of treatment that clinical personnel regard as either medically contraindicated or contrary to their conscience.

Clinical decision-making in relation to treatment options involves consideration of the patient's psychological and physical needs, as well as technical and moral aspects which, at times, may be difficult to reconcile. A request by the patient that life-saving treatment be withheld or withdrawn, may involve the physician in having to resolve a conflict between two ethical obligations. The physician's first ethical obligation is to act in accordance with the principle of non-maleficence. This fundamental principle of the Hippocratic tradition in medicine [FN377] focuses as much on the physician's engagement in the provision of benefit as on the avoidance of harm: "Declare the past, diagnose the present, foretell the future; practice these acts. As to disease, make a habit of two things--to help, or at least to do no harm." [FN378]

The classical principle of non-maleficence has been understood as tending toward circumspection rather than being action-oriented. [FN379] It guides the medical practitioner toward rendering help by avoiding conduct that may permit detriment or cause harm to the patient's best interests. The more modern, bioethical principle of beneficence has been defined as

an obligation to help others further their important and legitimate interests by preventing and removing harms; no less important is the obligation to weigh and balance possible goods against the possible harms of an action. This principle of beneficence potentially demands more than the principle of non-maleficence because it requires positive steps to help others, not merely the omission of harmcausing activities. [FN380]

Despite their superficial similarity, these two principles are philosophically and ethically separate, and may come into conflict with one another. [FN381] According to the Hippocratic tradition, in cases of conflict, the moral duty of non-maleficence, other things being equal, has priority. This may require an attempt by the medical practitioner to protect the patient from the harmful consequences of his or her choice when such a choice appears to be due to a major affective disorder, cognitive impairment, or abnormal illness behavior. At the same time, in cases where there exists a conflict between the patient and the treating physician, with respect to
preference in treatment options, the latter has to be conscious of his or her own psychological responses to a difficult situation and careful not to designate the patient's refusal of treatment as abnormal simply because such refusal is at odds with the physician's views on the issue. [FN382]

The second, though equally important, obligation of a medical practitioner is to respect the right of patients to make decisions about their own bodies and lives, and to ensure that the medical treatment accords with their wishes. When a legally competent patient appears to make a choice about treatment that is patently contrary to his or her well-being, these two obligations will come into conflict. [FN383]

Whenever a physician determines that the patient's choice is adversely affected by irrational considerations, be they conscious or unconscious, the physician will attempt to persuade the patient to change or modify that choice but, ultimately, once a legally competent patient has decided to refuse life-saving treatment, legally, the patient's decision must be obeyed. There is a curious anomaly in the legal rules that relate to the right of self-determination in the context of the physician-patient relationship. On the one hand, a medical practitioner has the right to refuse to administer medically contraindicated treatment requested by a competent patient on the ground that submission to such a request would be incompatible with the maintenance of the ethical integrity of the medical profession. On the other hand, the same physician has to respect the patient's right to die through refusal of medical therapy because of respect for the patient's right of self-determination. In both cases, no cause of action in battery will arise so long as the treating physician does nothing and leaves the patient free of uninvited physical contact. Nevertheless, in the first instance, "doing nothing" means noncompliance with the patient's wishes, in as much as the dignitary interests protected by law do not extend to the patient having a right to compel medical personnel to treat him or her in a particular way. In the second instance the physician stays within the law by complying with the patient's wish to die.

E. The Balance of Life and Death and the Refusal of Life-Saving Treatment

The fourth factor, regarded as decisive by Justice Skelly Wright in Application of President & Directors of Georgetown College, was the fact that Mrs. Jones' life "hung in the balance." [FN384] The present common law *66 regards the right to choose whether or not to undergo life-saving treatment as a manifestation of the individual's inalienable right to self-determination, which has to be respected regardless of the consequences of the decision. [FN385] Should the applicability of the absolute rule extend to cases where the refusal of life-saving treatment by a pregnant woman will inevitably result in her own death as well as the death of an otherwise viable fetus? In the case of Re T, Lord Donaldson MR noted, in obiter dictum, that an absolute right of competent adults to choose whether to consent or to refuse life-saving treatment may be qualified in a case "in which the choice may lead to the death of a viable fetus." [FN386] However, the Master of the Rolls left this question open.

Sir Stephen Brown P was probably referring to this "open question" when, in a 1992 English case of Re S (Adult: Refusal of Treatment), [FN387] he considered an application by a health authority for a declaration to authorize surgeons and staff of the hospital to carry out an emergency cesarean section operation upon Mrs. S, who was the mother of two young children. She was admitted to the hospital with ruptured membranes and in spontaneous labor, beyond the expected date of birth. By the time the matter came before court, the mother had continued in labor for six days, her situation was extremely serious, and the condition of the fetus was rapidly deteriorating. The position of the fetus was that of "transverse lie," with the elbow
projecting through the cervix and the head on the right side of the pelvis. Allowing
natural labor to continue was certain to cause rupture of the uterus and the consequent
death of the mother and the fetus. Mrs. S, a born-again Christian, refused the
operation on religious grounds. Nevertheless, Stephen Brown P granted the
declaration authorizing the cesarean section. In the judgment, which was completed
within the space of an hour, [FN388] Stephen Brown P emphasized that the situation
was one of "life and death," and the issue had to be determined within "minutes rather
than hours." [FN389] Indeed, the decision came too late for the child, but by acting on
the declaration, the physicians *67 were able to save Mrs. S's life. [FN390] Believing
that "God was acting through the agency of the gynaecologist," Mrs. S soon
reconciled herself with the situation and decided against appealing to the Court of
Appeal. [FN391] Nevertheless, Sir Stephen Brown's decision was greeted with at
times emotive [FN392] criticism by lawyers who regarded it as a "major intrusion into
the rights of women." [FN393]

The harsh criticism meted out to Stephen Brown P was well grounded in strict
legal doctrine, but revealed little in the way of humane understanding. Can a society
that calls itself civilized, countenance a situation where a young woman, carrying a
viable fetus, dies a cruel, but easily preventable, death from a ruptured uterus? Had
the judge refused to grant the declaration, the medical personnel attending Mrs. S,
qualified and able to prevent such disaster, would have been constrained from acting
by a principle of respect for her autonomy. In Re S, Stephen Brown P refused to
dogmatically apply an abstract legal doctrine that would have rendered his decision
legally unassailable, yet morally and socially indefensible.

Philosophical notions of personal autonomy, which form the foundations of the
jurisprudential principles of self-determination were formulated in the context of
survival, not annihilation. From a consequentialist point of view, there is a
fundamental difference between the outcome of a decision to consent to a life-saving
treatment and a decision to refuse such an intervention. Unlike those who make the
death choice, persons who consent to life-saving treatment at the very least preserve
the status quo, and also, by remaining alive, retain an opportunity to change their
mind at a later date. The recent evolution of the law has taken the principle of
autonomy to its ultimate conclusion—beyond survival. Therefore, the legal criteria for
evaluating the person's capacity to make autonomous choices need to be adapted to
take account of that extension. The consequentialist position based upon a simple
dichotomy between life and death may be too inflexible to adequately address the
variety of circumstances and factors that motivate individual death choices. At the
same time, the difference between the consequences of consent to and refusal of life-
saving treatment cannot be entirely ignored.

*68 The law has traditionally adopted a consequentialist approach when it
considered communitarian interests, such as the consequences of violent behavior on
public order, and disallowed consent to constitute an absolute defense to criminal
trespass to person. Reiterating the principle established by Lord Coleridge CJ in 1692
in the case of Matthew v. Ollerton, [FN394] Hawkins J stated in the 1882 case of R.
v. Coney [FN395] that "it is not in the power of any man to give an effectual consent
to that which amounts to, or has a direct tendency to create, a breach of peace; so as to
bar a criminal prosecution." Since the 17th century, the legal efficacy of consent
would not extend to the risk of death in duelling. [FN396]

The common-law rule that consent is no defense to unlawful wounding except in
cases of surgery, tattoos, contact sports, and "horse-play" [FN397] was codified in the
United Kingdom in the Offences Against the Person Act. [FN398] Justification for
this rule was provided by Lord Lane CJ in 1981 when he declared: "It is not in the public interest that people should try to cause or should cause each other bodily harm for no good reason." [FN399] Lord Lane added that the principle of "public interest" was not intended to "cast doubt upon the accepted legality of . . . reasonable surgical interference." [FN400] The case concerned two youths who, following a quarrel, agreed to have a fist fight, which resulted in a bloody nose and bruises to the face of one of them.

The rule was affirmed by the majority of the House of Lords in the case of R. v. Brown [FN401] in relation to a group of men who appeared [FN402] to have consensually engaged in extreme forms of sadomasochistic practices. [FN403] The House of Lords held that the prosecution does not have to prove lack of consent to infliction of actual harm in the course of sadomasochistic activity. [FN404] When the consent to bodily interference is provided voluntarily by a *69 competent person who has balanced the risks and benefits involved, the law distinguishes between operative and inoperative consent taking into consideration the following two factors: (1) the nature of the harm--whether or not the harm consented to is of minor nature, rather than manifesting itself as an actual bodily harm; [FN405] and (2) the reason for the harm--whether or not the harm was occasioned for a "good reason" or in "public interest." [FN406]

In cases where the interference cannot be justified on the grounds of "good reason" or "public interest" and the consensual conduct occasions actual, or serious, or grievous bodily harm, the victim's consent will be regarded in law as being of no consequence. In R. v. Brown, Lord Templeman rejected the contention that "every person has the right to deal with his body as he pleases." [FN407] Lord Mustill, in a dissenting judgment, paraphrased John Stuart Mill's words when he said:

The state should interfere with the rights of an individual to live his or her life as he or she may choose no more than is necessary to ensure a proper balance between the special interests of the individual and the general interests of the individuals who together comprise the populace at large. [FN408] Lord Mustill drew the line on the rights of individuals to choose how they may live beyond consent to sadomasochistic practices, but noted that the efficacy of consent does not extend to consensual killing. [FN409]

The common law's approach to consent is clearly consequential. Its legal efficacy depends entirely on the characterization of the purpose and the outcome of the consensual conduct in question. Consent to interference with one's body as an expression of the right to self-determination may be deemed inoperative when it is "other-oriented," for instance, in the cases of sexual enslavement or sadomasochistic activities. [FN410] However, the right to self-determination also may be "self-oriented," involving actions directed at one's body, for instance, self-mutilation. Here again, the approach of the *70 law is consequential--such acts of self-mutilation as ears, nose, and genital piercing tend to be regarded as legally acceptable, but self-mutilation that has the effect of endangering the person's productive capacity or health--cutting off one's hand--may be deemed outside the choices to which an individual has a legal right. A great majority of modern mental health statutes that regulate involuntary commitment stipulate that the certified person's conduct, which was the result of an impaired mental condition, constituted a danger to himself or herself. If the legal validity of consent--whether regarding self, or others--is not considered to be an absolute value but is determined in accordance with the sliding scale of harm, then one may ask why refusal of treatment should be deemed of absolute value irrespective of the harm thereby occasioned?
CONCLUSION

The orientation of the present law of trespass to person has moved too far away from general communitarian considerations implied by the principle that the best way to uphold public peace and social harmony is by effectively safeguarding personal integrity and dignitary interests of all individuals. The notion of an unalienable right to self-determination in matters relating to personal well-being had its origins in the law of contract, which developed under the influence of philosophical theories of social contract and utilitarianism. Transposed into the law of torts, the absolute right to refuse life-saving treatment gives rise to an inference that it is at least in part informed by the economic interest in reducing public health care expenditure. The preoccupation with absolute values is a relatively novel development in common law. Traditionally, the common law tended to be concerned with the individual rights and obligations within the "give and take" principles of community interests rather than with such abstract notions as absolute truth or absolute rights.

Conceptually, the legal right to self-determination is, undoubtedly, a very significant and essential element of modern jurisprudence--people, in general, should be able to exercise control over their bodies in relation to undertaking or cessation of any invasive medical regimen. Nonetheless, there are a number of profound moral and human questions that sit uneasily with the declaratory statements of an ideologically pure notion of personal autonomy. For instance, what are the legal criteria for distinguishing a suicidal refusal of treatment from merely an unreasonable one? At which point should an unreasonable refusal of treatment be treated as an indication of the absence of "sound mind" and the patient considered to be legally incapable of making a decision about treatment choices? Who should decide whether the particular refusal of life-saving treatment amounts to a passive suicide, and whether it is reasonable?

*71 A narrow, cognition-oriented legal standard for valid consent to life-saving medical treatment is sufficient when the consequence of that consent means survival, with the patient still retaining an option to change his or her mind. It is altogether insufficient, however, in cases where the refusal of treatment means death, which allows for no second chances.

There is a danger that an ideological purity of the right to refuse life-saving treatment as an expression of the right to individual self-determination may disguise other considerations. It is much less expensive to uphold the right to die of those who suffer from chronic paranoid schizophrenia, the clinically depressed, the disabled, the systemically ill, and those in pain than to care for them at home, in mental institutions, in prisons, hospitals, and hospices. Unless and until traditional notions of "sound mind" are modified to incorporate the modern medical understanding of affective capacity into the legal standard for valid consent to or valid refusal of life-saving medical treatment, the law will accord greater protection to the hale, the hearty, and the emotionally stable than to the diseased, the mentally ill, and those who are emotionally stressed either through pain or loneliness, or both.

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University, for their comments and helpful suggestions in the preparation of this article.

[FN1]. E. Coke, 6 Rep. 41. Throughout this article the phrase "common law" is used in its jurisprudential sense to denote the single national customary law, which in the late medieval period displaced the local and the baronial law in England, and to distinguish this system of law from the civil law of continental Europe, and the Scots law.


[FN5]. "Affect" refers to the immediate emotional experience. Subjective affective sensations such as pleasure, displeasure, irritation, as reported by a patient, are equivalent to symptoms; the observed mood and affective display (anger, joy, sadness, hurt) serve as objective signs. "Mood" refers to a more sustained and less flexible mental state over a longer period of time. In depression or schizophrenia, the affective sensations are often shallow, inadequate, or flattened. Ketai, Affect, Mood, Emotion and Feeling: Semantic Considerations, 132 AM. J. PSYCHIATRY 1215 (1975).

[FN6]. The patient's "choice is, in reality, meaningless unless it is made on the basis of relevant information and advice." Rogers v. Whitaker, 175 C.L.R. 479, 490 (1992).


[FN8]. Id. at 786.

[FN9]. Id. at 793.


[FN11]. Id. at 10-11.

[FN12]. Rogers, 175 C.L.R. at 490.

[FN13]. In rejecting the American doctrine of informed consent in negligence, the High Court of Australia followed the majority of the House of Lords in the case of Sidaway v. Governors of Bethlem Royal Hosp., [1985] A. C. 871.

[FN14]. Rogers, 175 C.L.R. at 490.

[FN15]. Id.
Although "assault" is a separate tort with its own set of elements, it is often, incorrectly, used as an appellation for the tort of battery.


Id. at 17, 25.

This principle is also applicable to the torts of assault and false imprisonment.


Mental Health Act (Vic.) of 1986 §§ 12, 13, 73, & 85.

A plea of necessity may provide lawful justification.

"The incision made by the surgeon's scalpel need not be and probably is most unlikely to be hostile, but unless a defence of justification is established it must in my judgment fall within a definition of a trespass to person." T. v. T., [1988] 2 W.L.R. 189, 203 (Wood, J.).

Secretary, Dep't of Health & Community Servs. (NT) v. JWB and SMB (Marion's Case), 175 C.L.R. 218, 309 (1992). The case involved the issue of whether parents or the family court should have the power to consent to a sterilization of their profoundly intellectually impaired daughter.

Id. at 233.

In re W (A Minor, Medical Treatment: Court's Jurisdiction), [1992] 3 W.L.R. 758, 765.

486 A.2d 1209 (N.J. 1985).

Id. at 1225.


Duels of honor--private combat in the form of consensual revenge for the perceived injury to the participants' honor and reputation--probably were the best known vestiges of "faida."

A "writ" was an order issued by the court in the sovereign's name under the Great Seal, addressed to the sheriff of the county in which the cause of action arose,
or where the defendant resided, commanding the sheriff to cause the party complained of to appear in the King's Court on a certain day to answer the complaint. Every writ was founded on a principle of law that gave the plaintiff the legal right to seek a specified remedy.


[FN35]. There was also an older form of private action--Appeal of Mayhem--an accusation of maiming, that was akin to action in Trespass for recovery of damages. The Appeal of Mayhem was different from the Appeal of Felony whereby a party--a widow or an heir--who had an interest in the person killed prosecuted an accusation of murder either by writ or bill. G. JACOB, NEW LAW DICTIONARY (1756).


[FN37]. J. FLEMING, supra note 17, at 17.

[FN38]. The principle that by being able to obtain compensation under the law of torts, the plaintiff was thereby induced to forgo the right to take revenge was--unsuccessfully--invoked as a basis for liability in Stanley v. Powell, [1891] 1 Q.B. 86.

[FN39]. The spelling of the Latin word "injuria" as "injurio" is the accepted common-law form of medieval Latin.


[FN41]. H. BRACTON, DE LEGIBUS AT CONSUETUDINIBUS ANGLIAE probably was written between 1240 and 1256. Id. at 2.


[FN43]. Id. at 557.


[FN45]. In medieval times, England was divided into areas known as circuits. Nottingham was one such circuit, and it would be visited four times a year by the court to decide all cases that had arisen since the last sitting of the court. Each session of sitting was referred to as an assize.


[FN47]. The writ of covenant--to secure enforcement of an agreement--was inapplicable because the loss of the eye did not result from a breach of agreement
through its nonperformance; it probably was due to the careless or incompetent performance of the agreed procedure.

[FN48]. 6 Mod. 149 (1704).


[FN51]. 364 A.2d 27 (N.J. Super. 1976). The husband was charged with the offense of "atrocious assault and battery."

[FN52]. Brown, 364 A.2d at 31-32.

[FN53]. Legal duels such as judicial combat, or ordeal by battle, introduced by the Normans constituted exception to the rule that a consensual premeditated killing should constitute murder. Horder, The Duel and the English Law of Homicide, 12 Oxford J. Legal Studies 419 (1992).


[FN57]. Referring to the Roman concept of personal freedom the "libertas," Cicero called it the "sweetest of all possessions."

[FN58]. J. Locke, The Second Treatise of Government § 5.27 (P. Laslett ed. 1970). It was Sir Edward Coke who stated, admittedly in a somewhat different context, that "the house of everyone is to him as his castle and fortress as well for his defence against injury and violence as for his repose." Semayne's Case, 5 Co. Rep. 91a (1604), [1558-1774] All E.R. 62, 63.


[FN62]. "Life is the immediate gift of God, a right inherent by nature in every individual." Id. vol. 1, at 125, 129-30 & vol. 3, at 119-20.
"In purity and in holiness I will guard my life and my art." L. EDELSTEIN, ANCIENT MEDICINE 6 (1987).

Corpus Hippocraticum consists of about 60 treatises, the collection of aphorisms, the Oath, and the Canon. Some of the treatises and aphorisms were written by Hippocrates (460 BCE). However, the Corpus as a whole is the work of a large number of medical writers of ancient Greece that was compiled between 430 and 300 BCE, with even later interpolations. HIPPOCRATIC WRITINGS (J. Chadwick & W. Mann trans. 1983).

On the Physician, Precepts, and On Decorum were written in Hellenistic times.

L. EDELSTEIN, supra note 63, at 328-29.

Id. at 59.


L. EDELSTEIN, supra note 63 at 6.

Id. at 17. The Pythagorean approach toward sanctity of life was akin to that of Judaism, which regards the human body not as property of an individual person, but that of the Creator. Individuals are merely custodians or trustees of their bodies, the ownership of which rests with the Creator. In Judaism, every person is charged with a positive duty to preserve health and life.

Id.

In classical times (5th-3rd century B.C.E.), the Greek City-State of Ceos mandated that people over the age of 60 end their life by drinking hemlock. In the Hellenistic period (3rd-1st century B.C.E.), the political authorities in Thebes and Massalia (modern Marseilles) supplied a free dosage of hemlock on application. Young, Cross-Cultural Historical Case Against Planned Self-Willed Death and Assisted Suicide, 39 McGill L. J. 657, 686, 689 (1994).


Several medical sects flourished during the Graeco-Roman period, amongst them were the Oulidai at Elea, the Methodists, the Asclepiadeans of Bithynia, the "Sicilian School," and others. Nutton, Healers in the Medical Market Place: Towards a Social History of Graeco-Roman Medicine, in MEDICINE IN SOCIETY: HISTORICAL ESSAYS 15 (A. Wear ed. 1994).

In Roman times, Stoicism often was seen as a spiritual alternative to the national religion. Philosophers were attached to many Roman families in the role of...
tutors and moral counselors. Thus, a philosopher, along with the physician, would often be present at a deathbed.

[FN77]. On the Physician (CMG I: 10, 21; 14, 1), quoted in L. EDELSTEIN, supra note 63, at 99.

[FN78]. Nutton, supra note 75, at 49.

[FN79]. L. EDELSTEIN, supra note 63, at 98.

[FN80]. 1 THE APHORISMS OF HIPPOCRATES i (Author's rendition) (trans. into Latin and English in T. COAR, THE CLASSICS OF MEDICINE LIBRARY (1982)). See also HIPPOCRATIC WRITINGS, supra note 64, at 206.

[FN81]. Hippocratic Oath reflects the beliefs of the Pythagoreans in the spiritual kinship between the medical teacher and pupil.

[FN82]. L. EDELSTEIN, supra note 63, at 329.

[FN83]. Galen (130-201 CE), in an essay entitled That the Best Physician Is Also a Philosopher, insisted that a true physician must be an adherent of Platonism, which by then was fused with Aristotelianism and Stoicism. L. EDELSTEIN, supra note 63, at 335.

[FN84]. 1 HIPPOCRATES: PRECEPTS 319 (W. Jones trans. 1923).

[FN85]. Kibre, Hippocratic Writings in the Middle Ages, 18 BULL. HISTORY MED. 371 (1945); MacKinney, Medical Ethics and Etiquette in the Early Middle Ages: The Persistence of Hippocratic Ideals, in LEGACIES, supra note 69, at 173.

[FN86]. The Hippocratic Canon was translated into Hebrew by Nathan Hameati of Rome in 1279. Etziony, The Hebrew-Aramaic Element in Vesalius' Tabulae Anatomicae Sex, 18 BULL. HISTORY MED. 413 (1945).

[FN87]. Kristeller, The School of Salerno, 17 BULL. HISTORY MED. 138 (1945).

[FN88]. Id.


[FN90]. The word "ius" has a number of meanings, however, in the context of jurisprudence it was understood as referring to the right of each person. The science, which consisted of knowing the "ius"--the right of each person--was called "ars iuris": the art of law, or the art of what is just. J. HERVADA, NATURAL RIGHT AND NATURAL LAW: A CRITICAL INTRODUCTION 20 (1990).

[FN91]. It was not until mid-19th century that the common law was taught at Oxford and Cambridge.

[FN92]. F. ALEXANDER & S. SELESNICK, THE HISTORY OF PSYCHIATRY
Galen and Hippocrates were first published in the original Greek in 1525 and 1526 respectively. Etzioni, supra note 86, at 414.


"If one which is no physician or surgeon . . . will take a cure upon him, and his patient dieth under his hand, this hath been holden to be a felonie." C. MERRET, A COLLECTION OF ACTS OF PARLIAMENT, CHARTERS, TRIALS AND LAW, AND JUDGES OPINIONS 66 (1660). See also IV E. COKE, INSTITUTES OF THE LAWS OF ENGLAND 251 (1648).

Henry VIII granted his letters patent under the Great Seal incorporating the President and College or Commonalty of the faculty of Medicine of London on 23 September 1518. 1 G. CLARK, A HISTORY OF THE ROYAL COLLEGE OF PHYSICIANS OF LONDON 58 (1964).

The College could not compel provincial candidates to come to London for examination. Moreover, throughout the provinces of Canterbury and York, the license that confirmed the physicians' right to practice came from the local diocesan bishop. Guy, supra note 94, at 533.

Within its jurisdiction, the officers of the College had the power to imprison and keep at their pleasure those who practiced medicine badly or without a license granted by the College. 14 & 15 Hen. 8, c. 5; 32 Hen. 8, c. 40; 1 Mariae, St. 2, c. 9. In this respect, the College had the characteristics of a prerogative tribunal.

Guy, supra note 94, at 533.


R. VAN CAENELEGEM, AN HISTORICAL INTRODUCTION TO PRIVATE LAW 127 (1988).

MacKinney, supra note 85.


Clark, Bernard Mandeville, M.D., and Eighteenth Century Ethics, in LEGACIES, supra note 69, at 270.

[FN108]. Id. at 10.

[FN109]. Id. at 12.

[FN110]. Id. at 39.

[FN111]. Id. at 35.

[FN112]. Id. at 22-23.

[FN113]. Id. at 35.

[FN114]. Id. at 33.

[FN115]. Larkey, supra note 104.


[FN118]. In all early cases where the pre-existing relationship precluded an allegation that force of arms had been used, the plaintiffs would use the writ of trespass sur le cas (special action on the case) with a count of "ita negligenter" (an adverb designated to indicate the alleged wrongful conduct).


[FN120]. Id. at 862.

[FN121]. "[A]lthough the defendants in general may be as skilful in their respective professions as any two gentlemen in England, yet the Court cannot help saying, that in this particular case they have acted ignorantly and unskilfully, contrary to the known rule and usage of surgeons." Id. at 863.

[FN122]. Id. at 862.


[FN124]. Id. at 765.

Percival's Medical Ethics became the foundation of the American Medical Association's first Code of Medical Ethics. AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS, PROCEEDINGS OF THE NATIONAL MEDICAL CONVENTION (1846-1847).


This article shall not discuss issues of consent that arise within such a relationship.

T. PERCIVAL, supra note 125, at 10-11 (emphasis in original).

Id. at 44-45 (emphasis in original).

Id.

Id. at 169.

J. GREGORY, supra note 107, at 60-63.

Id. at 63.

1 H. BALLOW, A TREATISE OF EQUITY WITH THE ADDITION OF MARGINAL REFERENCES AND NOTES BY JOHN FONBLANQUE (1793, reprinted 1979).

The popularity of Grotius and Pufendorf in England may be gauged by the fact that six editions of the former's De Iure Belli were published there before 1750. Between 1682 and 1758, at least nine editions of the Latin version of Pufendorf's De Officio Hominis et Civis Iuxta Legem Naturalem had appeared. There were also seven editions of the English translation, and one of the Barbeyrac's French version. P. STEIN, LEGAL EVOLUTION: THE STORY OF AN IDEA 3 (1980).

Id.

R. VAN CAENEGEM, supra note 102, at 118-19.

The principles of nature were the basis of the law of nature; principles of common consent were the basis of the law of nations. H. GROTIUS, DE IURE BELLII AC PACIS prolegomena § 40 (1623), quoted in P. STEIN, supra note 136, at 4.

1 H. BALLOW, supra note 135, ch. 1, § 1.

P. YOUNG, supra note 2, at 148-49.

H. GROTIUS, supra note 139, lib. 2, ch. 11, § 5.

1 H. BALLOW, supra note 135, ch. 2, § 1.
[FN144]. Id.

[FN145]. Id. § 1, n.(a).


[FN148]. Id. at 780 (emphasis added).


[FN150]. Id.

[FN151]. "Nam impetu quodam et instinctu procurrere ad mortem commune cum multis, deliberare vero et causas eius expendere, utque suaserit ratio, vitae mortisque consilium vel suscipere vel ponere ingentis est animi," See also Gourevitch, Suicide Among the Sick in Classical Antiquity, 43 BULL. HISTORY MED. 501, 514 (1969).

[FN152]. For a discussion of historical definitions of consent, see P. YOUNG, supra note 2, at 12-14.


[FN156]. J. MILL, ON LIBERTY (1859).

[FN157]. Id. at 9.

[FN158]. Id.

[FN159]. Id. at 11.

[FN160]. Id. at 12.

[FN161]. Id. at 9.


In 1765, Lord Camden, C.J. declared: "Our law holds the property of every man so sacred that no man can set foot upon his neighbour's close without his leave." Entick v. Carrington, 19 Howell State Tr. 1029 (1765), 95 E.R. 807, [1558-1774] All E.R. 41.

Rape was a punishable felony not so much because it violated the principle that "every man's person [is] sacred," but because it interfered with the proprietary right that a parent had in his daughter, and husband had in his wife.

The hedonistic principle of the utilitarian philosophy goes back to the Epicureans who advocated that their followers should decide how to achieve their aspirations to a virtuous life by way of balancing pleasure in the sense of "ataraxia" (a Greek word meaning serenity, tranquility, calmness of mind) against distress, discomfort, or pain.

The philosophers understood freedom as an objective state of the body rather than as a datum of consciousness or a state of mind--basic freedom was freedom of movement.

ST. AUGUSTINE, DE LIBERO ARBITRIO, bk. III, v-viii.

H. ARENDT, THE LIFE OF THE MIND: WILLING 29 (1978). Greek philosophers understood freedom as an objective state of the body rather than as a datum of consciousness or a state of mind--basic freedom was freedom of movement.

ST. AUGUSTINE, DE LIBERO ARBITRIO, bk. III, v-viii.

[FN183]. 104 N.W. 12 (Minn. 1905). The passage also was quoted with approval in Rolater v. Strain, 137 P. 96, 97 (Okla. 1913). Mohr v. Williams was overruled on other grounds in Genzel v. Halvorson, 80 N.W.2d 854, 859 (Minn. 1957).


[FN185]. The Supreme Court of Illinois in Pratt, 79 N.E. at 562 also discussed the exception of necessity.

[FN186]. Mohr, 104 N.W. at 15.

[FN187]. Id.

[FN188]. 159 S.W. 122 (Tex. App. 1913).

[FN189]. Id. at 124.


[FN193]. J. MASON & R. McCALL SMITH, LAW ANDMEDICAL ETHICS 219-20 (4th ed. 1994). The authors distinguish between nonvoluntary therapy and an involuntary treatment, which implies treatment against a competent patient's express wishes. Legal acceptability of involuntary treatment depends upon a balance between the personal interest in autonomy and the interests of life, safety, or welfare of a third party, of the community. In relation to the enforcement of compulsory vaccination, see Prince v. Massachusetts, 321 U.S. 158 (1944).


[FN195]. 137 P. 96 (Okla. 1913).

[FN196]. Id. at 96.

[FN197]. Id. at 99.

[FN198]. The sesamoid bone can be found in the tendons of flexor hallucis brevis, the muscle that bends or flexes the big toe. R. SNELL, CLINICAL ANATOMY FOR MEDICAL STUDENTS 38 (4th ed. 1992).
In this case, during the course of an operation under a general anesthetic, the defendant surgeon found that to repair a hernia, which was the authorized procedure, he would have to revise the patient's ileostomy. He did both procedures, and subsequently was sued successfully by the patient. The court determined that a hernia repair was not the kind of surgery undertaken to preserve the patient's health or life, and, because the original procedure could not be carried out without performing the unauthorized procedure, neither operation was permissible.


The doctrine of implied consent, which is based on the maxim "qui tacet, consentire vedetur" (he who is silent is deemed to have consented), operates in general physician-patient relationships when the patient is lucid, for example, when a person holds up an arm to be vaccinated--it will be taken as a valid assent to the procedure. O'Brien v. Cunard SS Co., 28 N.E. 266 (Mass. Sup. Jud. Ct. 1891).

The suppository was inserted--mistakenly--into the patient's vagina, instead of her rectum.

General Medical Council of the United Kingdom was set up under the Medical Act 1858 (UK). It has regulatory powers, including the power to remove from the Register a practitioner found guilty of infamous conduct in professional respect. As such, it is a prerogative tribunal and a part of the executive arm of the government.

Mitchell, supra note 200, at 43. The dental surgeon who had never touched the diclofenac suppository was found guilty of assault and serious professional misconduct by the General Dental Council on the same facts.

McCoid, A Reappraisal of Liability for Unauthorized Treatment, 41 MINN. L. REV. 381 (1957).

In Foster v. Wheeler, 36 Ch. C.D. 695, 698 (1887), Kekewich, J. defined contract as "[a]n act in the law whereby two or more persons declare their contract as to any act or thing to be done or forborne by some or one of those persons for the use of the others or other of them." See also Cundy v. Lindsay, 3 App. Cas. 459, 465 (1878).

105 N.E. 92 (N.Y. 1914).

Id. at 93.


Id. at 90.

Id. at 22, 82.


[FN214]. 1 W. BLACKSTONE, supra note 61, at 129-30.


[FN217]. Id.


[FN221]. Id. at 1008.

[FN222]. Id. at 1009.

[FN223]. Id.

[FN224]. Id. at 1009-10.

[FN225]. F. ROZOVSKY, supra note 3, at 442.


[FN227]. The opening clause of the first amendment to the United States Constitution states that "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof." The first 10 amendments were ratified in 1791 and form what is known as the American Bill of Rights.

[FN228]. Georgetown College, 331 F.2d at 1000.

[FN230]. Id. at 478.

[FN231]. Georgetown College, 331 F.2d at 1016-17.

[FN232]. Cruzan, 497 U.S. at 271.

[FN233]. Quinlan, 355 A.2d at 663.

[FN234]. Cruzan, 497 U.S. at 278-80.

[FN235]. The language of the decision in Cruzan is ambiguous. However, it is clear from the judgment that the Court--for the purpose of deciding the case--assumed the existence of the right to refuse life-sustaining treatment.


[FN237]. State interest in the preservation of life is enshrined in the American Declaration of Independence and the Constitution of the United States.

[FN238]. Saikewicz, 370 N.E.2d at 425; Cruzan, 497 U.S. at 271.


[FN240]. Justice Scalia said that his preference would have been for a determination that "the federal courts have no business in this field." Cruzan, 497 U.S. at 293 (Scalia, J., concurring).


[FN243]. 225 Cal. Rptr. 297 (Cal. App. 1986). Elizabeth Bouvia, a quadriplegic suffering from cerebral palsy, sought injunctive relief to order the High Desert Hospital to accede to her request and remove the nasogastric tube through which nutrition and hydration were supplied to keep her alive. The appellate court granted the injunction. In early 1989, she was still alive with the help of a nasogastric tube. G. PENCE, 44 CLASSIC CASES IN MEDICAL ETHICS (1990).

[FN244]. Bouvia, 225 Cal. Rptr. at 300.


[FN246]. Id. at 864, 826-27 (Hoffman, L.J.).

[FN247]. Georgetown College, 331 F.2d at 1009.

[FN248]. See also In re Estate of Brooks, 205 N.E.2d 345 (III. 1965), where the court
said that the patient may elect to pursue religious beliefs by refusing life-saving blood transfusions, provided the decision did not endanger public health, safety, or morals.

[FN249]. 1 H. BALLOW, supra note 135, ch. 2, § 1.


[FN252]. [1870] 5 Q.B. 549.

[FN253]. Id. at 565.

[FN254]. The phrase "natural faculties" has been interpreted in modern testamentary law as including "amongst other things, a comprehension and appreciation of the claims [by relatives, etc.] to which the testator ought to give effect." In re Estate of the Late Donald Harold Bonson, slip. op. at 18 (unreported) (Sup. Ct. Northern Territory, Apr. 7, 1995) (Martin, C.J.).


[FN256]. Major affective disorders are characterized by a prominent and persistent disturbance of mood (depression or mania). The disorder is usually episodic but may be chronic. A PSYCHIATRIC GLOSSARY 87 (A. Werner, R. Campbell, S. Frazier, & E. Stone eds. 5th ed. 1980).

[FN257]. Banks, [1870] 5 Q.B. at 566.

[FN258]. In the Australian and English jurisdictions the rules of criminal insanity in the McNaghten's Case, 10 Cl. & F. 200, 8 E.R. 718 (1843), provide the legal test for the insanity defense. Mawson, Specific Defences to a Criminal Charge: Assessment for Court, in PRINCIPLES AND PRACTICE OF FORENSIC PSYCHIATRY (R. Bluglass & P. Bowden eds. 1990).


[FN261]. Re Hodges, (1988) 14 N.S.W.L.R. 698, 706 (Powell, J.) (emphasis added); applying Re Crichton, and Re Crooks (unreported) (Sup. Ct. New South Wales, Probate Div., Dec. 4, 1994). See also Judge Santow's statement that it is no longer "necessary to find a disorder of the mind in any clinical sense. The delusion must be tested by objective evidence, as to it being fixed, false and incorrigible such as that the testator could not be reasoned out of it. Such delusions or disorders of the mind
thus go beyond eccentricity, or vindictiveness, or irrationality, though these may be
evidence pointing with other material, to lack of testamentary capacity." Easter v.
Griffith, slip. op., at 9 (unreported) (Sup. Ct. New South Wales, Probate Div., June
17, 1994). With due respect, Judge Santow's test while dispensing with the medical
explanations, is so vague and broad that it provides no definable standards, and thus
endows the court with an untrammelled discretion.


[FN263] In re Conroy, 486 A.2d at 1225; malette, 67 D.L.R.4th at 328; Marion's


[FN265] Brown, Cartesian Dualism and Psychosomatics, 30 PSYCHOSOMATIC
322 (1989); McCartan, Monism and Dualism: New Lamps for Old, 107 J. MENTAL
SCI. 809 (1961); Einsenberg, Disease and Illness, 1 CULTURE, MED. &
PSYCHIATRY 9 (1977); Langley & Brand, The Mind-Body Issue in Early
Twentieth-Century American Medicine, 46 BULL. HISTORY MED. 171 (1972); D.

[FN266] B. SPINOZA, PRINCIPLES OF CARTESIAN PHILOSOPHY (1663) (H.

[FN267] B. SPINOZA, ETHICS (W. Hale trans., revised A. Hutchison Stirling, 4th
ed. 1937).

[FN268] D. KLEIN, supra note 265, at 357-58. Gottfried Wilhelm Leibnitz (1646-
1716) later transformed the maxim by adding "nisi intellectu ipse": there is nothing in
the intellect that had not originated in sensory experience, "except for the intellect
itself." Id. at 375.

1929).

[FN270] D. KLEIN, supra note 265, at 482.


[FN273] R. VIRCHOW, DIE CELLULAR-PATHOLOGIE IN IHRER
BEGRUNDDUNG AUF PHYSIOLOGISCHE UND PATHOLOGISCHE
GEWEBELEHRE (1858).

[FN274] Eisenberg, supra note 265; Jennings, The Confusion Between Disease and
Illness in Clinical Medicine, 135 CAN. MED. A.J. 865 (1986).

[FN275] Gutheil, Bursztajn, Brodsky, & Alexander, Affective Disorders,


[FN277]. The form was supposed to be countersigned by the medical practitioner, but it was not so signed. Although the form required that its contents and significance be explained to the patient, it was neither read nor explained to Ms. T.

[FN278]. Re T, [1992] 3 W.L.R. at 795. The Court of Appeal recognized that apart from the narrow issue of whether Judge Ward's declaration should be affirmed or dismissed, the appeal also had a wider purpose of providing guidance to hospital authorities and to the medical profession on the appropriate response to the refusal by an adult to accept treatment. For a further discussion of this case, see Mendelson, supra note 4.

[FN279]. Id. at 797. Lord Donaldson MR added that arguments for refusal of treatment based upon religious beliefs when deployed by someone in a very close relationship with the patient, "should alert the doctors to the possibility--no more--that the patient's capacity or will to decide has been overborne. In other words, the patient may not mean what he says." Id.

[FN280]. The utilitarian rule of impartiality fits in well with the common law's set of normative principles known as the rule of law, including the substantive principle of justice, which says that like should be treated alike, and that unfair discrimination should not be sanctioned by law.


[FN282]. See Malette, 67 D.L.R. 4th at 321, in which the defendant physician who administered blood transfusions to an unconscious card-carrying Jehovah's Witness was held liable for battery. The condition of the patient at the time was critical and transfusion was necessary to preserve her life. The physician argued that he was not satisfied that the card expressed the current view of the plaintiff.


[FN286]. Sorenson, Suicide among the Elderly: Issues Facing Public Health, 81 AM.
From 1980 through 1986, there were 36,798 suicides reported among United States residents over the age of 65 years. Meehan, Saltzman, & Sattin, Suicides among Older United States Residents: Epidemiologic Characteristics and Trends, 81 AM. J. PUB. HEALTH 1198, 1198 (1991).


The death certificate listed the cesarean section as a "contributing cause" of the patient's death.

AC, 573 A.2d at 1248.

For a discussion of the AC case, see Witting, supra note 386, at 200.

Coyle, Adelhardt, Foley, & Portenoy, Character of Terminal Illness in the Advanced Cancer Patient: Pain and Other Symptoms During the Last Four Weeks of Life, 5 J. PAIN & SYMPTOM MNGMT. 83 (1990); Foley, The Relationship of Pain and Symptom Management to Patient Requests for a Physician-Assisted Suicide, 6 J. PAIN & SYMPTOM MNGMT. 289 (1991); Ramsay, Referral to a Liaison Psychiatrist from a Palliative Care Unit, 6 PALLIATIVE CARE 54 (1992).


Folstein, Fetting, Lobo, Niaz, & Capozzoli, Cognitive Assessment of Cancer Patients, 53 CANCER 2150 (1984); Anthony, LeResche, Niaz, von Korff, & Folstein, Limits of the "Mini-Mental State" as Screening Test for Dementia or Delirium among Hospital Patients, 12 PSYCHOLOGICAL MED. 397 (1982).

The Mini-Mental State test is specifically designed, through a series of 11 questions, to examine the memory registration and immediate recall, orientation, attention and calculation, short-term memory, and certain aspects of the use of language. The test also evaluates the patient's ability to follow verbal or written commands and his or her constructional ability. The patient's answers are scored, and the level of impairment assessed on the basis of the score out of 30 points. G. MENDELSON, supra note 285, at 44.


Bruera, et al., supra note 294.
[FN299]. Id. at 194.


[FN303]. Id. at 111.


[FN305]. Id. at 1033.

[FN306]. Id. at 1035.

[FN307]. Id. at 1036.


[FN309]. Id.


[FN311]. Bursztajn, et al., supra note 259. See also Levin, Brekke, & Thomas, A Controlled Comparison of Involuntary Hospitalized Medication Refusers and Acceptors, 19 BULL. AM. ACAD. PSYCHIATRY & L. 161 (1991) (in some jurisdictions in the United States involuntarily hospitalized psychiatric patients have the right to refuse medication).


[FN313]. Id. at 798.

[FN314]. Id. at 796.

[FN315]. Id. at 799.


[FN317]. Id. at 822. Mr. C also declared his complete faith in God and, subject to one
reservation, in the Bible.

[FN318]. Id.

[FN319]. Id. at 823.


[FN321]. Id. at 393.

[FN322]. There are also forms of abnormal illness affirmance, such as Munchausen's Syndrome, factitious disorders, somatoform disorders, hypochondriacal delusions, and the like.

[FN323]. Pilowsky, supra note 320, at 393. Anosognosia, which refers to the apparent unawareness of, or failure to recognize, one's own functional defect (hemiplegia, hemianopia) is a well-known neurological deficit, which also comes within the category of abnormal illness behavior.


[FN331]. Evans, Manninen, & Dong, An Economic Analysis of Liver
Transplantation: Costs, Insurance Coverage, and Reimbursement, 22
GASTROENTEROL. CLIN. NORTH. AM. 451 (1993); Evans, Manninen, & Dong,
An Economic Analysis of Heart-Lung Transplantation: Costs, Insurance Coverage,
and Reimbursement, 105 J. THORAC. CARDIOVASC. SURG. 972 (1993); Dodson,
Ingraham, Millikan, Henderson, Ricketts, Galloway, Olson, Caplan, Schoen, &
Perlino, Pediatric Liver Transplantation in Georgia: A Paradigm for the Health Care
Crisis in the United States?, 60 AM. SURG. 118 (1994); Loisance & Sally, Cost-
Effectiveness in Patients Awaiting Transplantation Receiving Intravenous Inotropic
Support, 8 EUR. J. ANAESTHESIOL. SUPP. 913 (1993).

[FN332]. Arras & Dubler, Bringing the Hospital Home: Ethical and Social
Implications of High-Tech Home Care, 24 HASTINGS CENTER REP. S19
(Sept./Oct. 1994); Brakman, Adult Daughter Caregivers, 24 HASTINGS CENTER
REP. 26 (Sept./Oct. 1994); Snelling, The Effect of Chronic Pain on the Family Unit,
19 J. ADV. NURS. 543 (1994); Doyal & Wilsher, Withholding and Withdrawing Life
Sustaining Treatment from Elderly People: Towards Formal Guidelines, 308 BRIT.
MED. J. 1689 (1994).

[FN333]. These instruments empower people who anticipate that they may become
unconscious while being under or in need of medical treatment to refuse beforehand

[FN334]. The provisions of the Patient Self-Determination Act, 42 U.S.C. §
139cc(f)(1)(A)(i) (Supp. V 1993) stipulate that every patient being admitted to a
health care facility that receives Medicare or Medicaid funds must be informed about,
and provided an opportunity to sign an advance directive. Persels, Forcing the Issue of
Physician-Assisted Suicide, 14 J. LEGAL MED. 93 (1993); Annas & Miller, supra
note 327, at 368. See also Emanuel & Emanuel, The Economics of Dying: The

[FN335]. Robinson, Philosophical Origins of the Economic Valuation of Life, 64
MILBANK Q. 133 (1986).

[FN336]. Id. at 150.

[FN337]. The Northern Territory Rights of the Terminally Ill Act, 1995 (RTIA)
received assent on June 16, 1995 in Australia. This law was enacted to "confirm the
right of a terminally ill person to request assistance from a medically qualified person
to voluntarily terminate his or her life in a humane manner; to allow for such
assistance to be given in certain circumstances without legal impediment to the person
rendering the assistance," and to provide procedural protection against the possibility
of abuse of the rights recognized by the legislation.

[FN338]. Miller, Denial of Health Care and Informed Consent in English and
American Law, 18 AM. J. L. & MED. 37 (1992); Henry, Debits and Credits in the
Management of Depression, 20 BRIT. J. PSYCHIATRY SUPP. 33 (1993); Healy,
Psychopharmacology and the Ethics of Resource Allocation, 162 BRIT.J.
PSYCHIATRY 23 (1993); Metcalf, Is Heart Transplantation a Wise Use of Scarce
Health Care Dollars?, 149 CAN. MED. A.J. 1829 (1993) (editorial); Mehlem &
Massey, The Patient-Physician Relationship and the Allocation of Scarce Resources:


[FN341] Id. at 380 (quoting J. MILL, supra note 156, at 13).

[FN342] Id. at 379.

[FN343] Id. at 390.

[FN344] Id.

[FN345] Id. at 389.


[FN347] Georgetown College, 331 F.2d at 1009.

[FN348] A detailed examination of different characterizations of the nature of the physician-patient relationship in law and medicine is too far removed from the main subject of this article.

[FN349] "I will come for the benefit of the sick, remaining free of all intentional injustice." L. EDELSTEIN, supra note 63, at 6.

[FN350] N. LAOR & J. AGASSI, EPISTEME 15: DIAGNOSIS: PHILOSOPHICAL AND MEDICAL PERSPECTIVES (1990). This kind of approach has been labeled as "paternalistic."

[FN351] [1985] A.C. 871, 904.

[FN352] Schloendorff, 105 N.E. at 93.


[FN356] Id. at 423.

[FN357] Id. The fiduciary duty involved not only provision of information concerning the patient's health in the physician's medical records, but extended to "the obligation to grant access to the information the doctor uses in administering
treatment." Id. at 424.

[FN358]. This kind of trusting relation is characteristic of partnership, agency, trusteeship, the relationship between employer and employee, solicitor and client, as well as companies and directors. A gain derived through breach of a "trusting relationship" may be reversed through equity's gain-stripping remedies. J. GLOVER, COMMERCIAL EQUITY FIDUCIARY RELATIONSHIPS 6 (1995).


[FN361]. Id. at 515.


[FN363]. Id.

[FN364]. Breen v. Williams (Ct. App. Sup. Ct. New South Wales, Dec. 23, 1994) (unreported) (Kirby, P., Mahoney, and Meagher, J.J.A.). In this case, the plaintiff argued, inter alia, that the fiduciary relationship between a medical practitioner and a patient creates an interest held by the patient in all medical records produced by the physician in relation to the administration of treatment. The physician's fiduciary duty of loyalty and care to the patient obligates the physician to allow the right of physical access to all documents whenever the patient or his or her agent makes a request, rather than through the process of the court's subpoena. The majority of the Court of Appeal rejected this argument.

[FN365]. Id.

[FN366]. Id. (Mahoney, J.).

[FN367]. United States Surgical Corp. v. Hospital Products Ltd., 157 C.L.R. 41 (1984); Hawkins v. Clayton, 164 C.L.R. 539, 553-54 (1988). In Moore v. Regents of the Univ. of Cal., 221 Cal. Rptr. 146, 150 (Cal. 1990), the Supreme Court of California, pointed out that "a physician is not the patient's financial adviser."


[FN370]. In re W (A Minor, Medical Treatment: Court's Jurisdiction), [1992] 3
W.L.R. 758, 767.


[FN372]. Id. at 516, 519-20 (Belacombe & Leggatt, L.JJ., concurring).


[FN375]. Id. at 41.


[FN378]. L. EDELESTEIN, supra note 63, Epidemias, I, 11, Hippphras Oper., at 14; 1 W. JONES, HIPPOCRATES 165 (1923-31). Latin maxim primum (or saltem) non nocere [above all, at least do no harm] probably comes from Galen.


[FN380]. Beauchamp, supra note 20, at 4-5.

[FN381]. A classic example of the conflict between the principle of non-maleficence and the doctrine of beneficence is that of euthanasia, where the idea of doing good, in the sense of cutting short, or preventing further suffering by annihilating the sufferer, is inimical to the notion of at least doing no harm.

[FN382]. Pilowsky, supra note 320, at 392.


[FN384]. Georgetown College, 331 F.2d at 1009-10.


[FN389]. In the course of his judgment, Stephen Brown, P referred to the decision in the case of In re AC, 573 A.2d 1235 (D.C. App. 1990), and suggested the possibility that American courts likely would be in favor of granting a declaration in the case of Mrs. S. It has been asserted that this reference amounted to "a significant reliance
upon AC's case." See Witting, Forced Operations on Pregnant Women: In Re S Examined, 2 TORTS L.J. 193 (1994); I. KENNEDY & A. GRUBB, MEDICAL LAW: TEXT AND MATERIALS 347, 359, 937 (1994). This assertion is incorrect. The circumstances in Re AC differed markedly from those in Re S. The issue that had to be determined in Re AC did not involve life-saving treatment for the mother, but a slim possibility of salvaging the fetus. Moreover, American precedent is at best persuasive in the United Kingdom.


[FN391] Id. at 63 Mrs. S was urged to appeal by, amongst others, Margaret Puxton, QC who said that "the decision [of Stephen Brown, P] would probably be overruled by the Court of Appeal," and Allan Levy, QC, who expressed a hope that the case would go to appeal because it was "too important not to go. It should go to the House of Lords." Levy added that Mrs. S "could also bring a civil action for assault if the Appeal Court ruled that the High Court declaration was wrongly made." Dyer, British Court Orders Caesarean Section, 305 BRIT. MED. J. 978 (1992). One wonders who would be the defendant in Mrs. S's action for battery--because the hospital and the physicians had acted under the authority of the law.


[FN394] [1692] Comb. 218, 90 E.R. 438.

[FN395] [1882] 8 Q.B.D. 534, 553.

[FN396] The law--though not necessarily the juries--considered duels of honor involving formal arrangements and the presence of seconds as a premeditated murder, however, the "spur-of-the-moment" duels by chance medley were regarded as unpredimeditated, thus amounting to manslaughter. Horder, supra note 53.


[FN398] Offences against the Person Act (U.K.), 1861, §§ 20 & 47.


[FN400] Id.

[FN401] [1993] 2 W.L.R. 556.

[FN402] According to the evidence, alcohol and drugs were employed to encourage consent by some of the participants.

Although the House of Lords did not cite the United States case of State v. Brown, 364 A.2d 27 (N.J. Super. 1976), its reasoning was not dissimilar. In Canada, in R. v. Jobidon, [1991] 2 S.C.R. 714, the Supreme Court held that consent was ineffective when bodily harm was intended and caused. For the Australian position, see Marion's Case, 175 C.L.R. 218 (1992).

Lord Slynn, in the minority decision, considered that the line of availability of consent as a defense should be drawn at the level of the infliction of serious bodily harm.

According to Lord Lowry, "public interest" may include conduct designed for "the enhancement or enjoyment of family life or conducive to the welfare of society." R. v. Brown, [1993] 2 W.L.R. 556, 563.

Id. at 564.

Id. at 600.


Ian Freckelton has observed that in the context of sadomasochistic activities it was possible to regard the acts in question "as inflicted at the hands in effect of a self-mutilator rather than by another person." Freckelton, supra note 403, at 63.