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Evolving standards of information disclosure:

Reform of Saudi Arabian medical law in the light of the developments of English law.

Khalid Ahmad Alghamdi

LLM in Law, Medicine and Healthcare (the University of Liverpool, the UK). LLB (King Abdulaziz University, Saudi Arabia).

Submitted in fulfilment of the requirements for the Degree
of Doctor of Philosophy

School of Law
College of Social Sciences
University of Glasgow

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Abstract

The major concern of this thesis is about the current professional standard of care under Saudi Arabian medical law, regarding doctors' duty to disclose information and risks to competent adult patients about a proposed medical treatment. Additionally, the thesis has highlighted other legal deficiencies that occur as a result of applying the professional standard in Saudi Arabia and considered how reforms can be introduced, based on English law experience in a way that is in harmony with Islamic *Sharia*.

The thesis has undertaken a novel approach by critically studying and comparing the current practice in Saudi Arabian medical law to the comparative English law approach. The reason for this is to provide a comprehensive legal literature review based on the extremely well-developed English law experiences in the same matters.

Realising the significance of the principle of the respect for autonomy, the thesis has placed a noticeable emphasis on this principle by arguing that considering and respecting autonomy would lead the law to protect the patient's autonomy and self-determination in a medical context. The thesis has argued that both Western and Islamic *Sharia* medical ethics have considered the notion of the respect for patients' autonomy, but that consideration has been approached differently, as the thesis has shown.

Further, the thesis has critically discussed how the English law standard of care has been developed in the last three decades, in order to move from the professional standard of care to a new standard that protects patients' autonomy and self-determination. These developments and years of experience have provided sufficient arguments and supports for the thesis's motion to recommend and suggest that Saudi Arabian medical law departs from the professional standard and adopts the prudent patient standard to protect patients' autonomy in compliance with Islamic *Sharia*.

In addition to proposing a legal formula for the prudent patient standard that can be adopted by Saudi Arabian medical law, this thesis has also proposed other formulas as solutions for other legal deficiencies, based on English law experience and in accordance with Islamic *Sharia*.

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Finally, I remain accountable for the arguments I have stated in this thesis and obviously for any errors.

¹ S Abi Dawud *Sunan Abi Dawud* at <http://sunnah.com/abudawud/43/39> (accessed 09/09/2015).

Declaration

I declare that, except where explicit reference is made to the contribution of others, that this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Signature:

Name: Khalid Alghamdi

Introduction

This thesis is concerned with the current Saudi Arabian legal approach to the standard of care required of doctors in providing information to adult competent patients about proposed medical treatment. This will include consideration of; the quality and quantity of information provided and the amount of information on risk that should be disclosed; whether doctors should inform the patient about the alternative available treatment options when seeking consent to treatment; the duty to answer patients' questions; the need to ensure that patients' understand the information given and the application of the therapeutic exception to withhold information. It will also consider the way in which complaints about doctors' provision of information are dealt with by the Saudi Arabian legal system, in particular in its reliance on the professional standard to establish doctors' liability.

As a way of examining the adequacy of the current legal approach in Saudi Arabia, this thesis will compare it with the English legal position. It will discuss the development of the law in both jurisdictions and what the law does and should be seeking to achieve. Evaluation of the adequacy of the two legal approaches will involve considering the ethical concept of respect for autonomy and its origins in Western¹ medical ethics and its place in Islamic *Sharia* in the context of consent and information disclosure.

English law has been selected as a comparator to Saudi Arabian law for the following reasons.

First, there have been many comparative studies and researches which have been written to compare Saudi Arabian or Islamic laws to English law and presented the possibility as how to learn some lessons from English law. Other studies and researches have been focusing on the relationship between Saudi Arabian or Islamic laws and English law. Most of this studies and researches show that there are several common areas and grounds between Islamic and Saudi Arabian laws and English law in various aspects of law such as commercial, arbitration, administrative, criminal and so forth

Those common areas can found in the following examples:

- A. A Legal Comparative Study of Judicial Review of Administrative Action in Saudi and English Law. (Thesis submitted to the University of Newcastle in 2015 by Naif Binlebdah).

¹ In general, the concept of Western has been used to describe in a single word the political, economic, social movement, culture, ethics and so forth that occurred in Europe and North America in the 19th century. W Bynum *et al.* *The Western Medical Tradition: 1800-2000* (1sted CUP 2006) P. 11-15.

- B. The Saudi Arabian Arbitration Regulations: a Comparative Study with the English Act of 1996 and the Arbitration Scotland Act of 2010 (Thesis submitted to the University of Stirling in 2015 by Albara Abulaban).
- C. A Research to Develop English Insurance Law to Accommodate Islamic Principles. (Thesis submitted to the University of Manchester in 2013 by Mahfuz Mahfuz).
- D. Frustration of Performance of Contract: A Comparative and Analytic Study in Islamic Law and English Law. (Thesis submitted to Brunel University in 2013 by Ibrahim Alhowaimil).
- E. A Study of Islamic Law and English Common Law on Aspects of Islamic Finance Securitisations. (Thesis submitted to University of Oxford in 2010 by Hanaan Balala).
- F. The Law Regarding Universities in Saudi Arabia and England: A Comparative Study. (Thesis submitted to the University of Newcastle in 2000 by Hussain AlSharif).

This shows that it has been accepted that both legal systems can benefit from each other and that some principles can be extracted in order to be adjusted then adopted. Therefore, following on the same path and precedents this thesis applied the same approach to compare Saudi Arabian law to English law in the area of medical law.

Second, Islamic *Sharia* has no barrier to learn from other legal systems whatever their background, so long as they are not in conflict with its principles. Therefore, in terms of offering a comparative study, I contend that the differences between legal systems do not mean that one cannot learn from another's experiences and approaches. It can be argued that, in respect of a different aspect of medical law, in developing some aspects of Saudi Arabian medical law, it is justifiable and appropriate to learn from English law experiences and developments. Of particular significance here, given the subject of this thesis, which seeks to compare an Islamic state's laws with those of a Western secular state, is the statement by scholar Ibn Qayyim AlJawziyyah (1292-1350),² one of the most respected and influenced Muslim scholars. He declared that Islamic *Sharia* is not only the teaching and understanding of its two main sources – the holy *Quran* and Messenger PBUH *Sunnah* traditions – but also the recognition of all other jurisprudences, principles and experiences that do not conflict with them.³ A similar view was expressed by the Saudi Arabian Grand *Mufti* and head of Saudi scholars, scholar Abdulaziz ibn Baz (who held this position from 1993 until his death

² L Holtzman 'Ibn Qayyim alJawziyyah' in *Essays in Arabic Literary Biography: 1350-1850* (Book 17) in R Allen, J Lowry and D Stewar (eds) (Harrassowitz Verlag 2009) p. 202-223.

³ M Ibn Qayyim alJawziyyah *Altorq Ahokmih fi Alsiash Alshreeh (Islamic Judicial Procedure)*. (1sted Dar Elhadith Publishing, 2002) p. 17-18. (Arabic).

in 1999).⁴ When he was asked about the Islamic *Sharia* view regarding the applying of non-Islamic laws into Islamic country legal system, the Grand *Mufti* Abdulaziz said that, as long as the law is in a harmony with Islamic *Sharia* traditions, not in conflict with them, and is in the public interest, then it is acceptable to adopt and apply non-Islamic law.⁵ Although there are obvious differences between the backgrounds of Saudi Arabian and English law - for example, different legal origins - both systems share some similar legal aspects⁶ which suggests there may be some similarities to be found in the types of provisions that apply to protect patients' autonomy and rights. For example, in *The Fiqh of Medicine Response in Islamic Jurisprudence to Development in Medical Science*⁷; the author has argued that some of the medical principles in Islamic *Sharia* and English law coincide. One of them is the application of the professional standard of care, where Islamic *Sharia* has applied the same reasoning as is found in the *Bolam* test,⁸ which used to be applied by English law.⁹ Thus this book shows that there is a common sense and ground between some of Islamic *Sharia* and English law principles which make it a valuable comparator.

Third, English law is a common law jurisdiction and therefore it differs from Islamic *Sharia* and Saudi Arabian law. This difference, however, reinforces the value of the comparison, as it allows for in-depth consideration of any barriers to the absorption of legal principles from one legal tradition into another. Furthermore, the same legal problems that English law has dealt with during the last 30 years since the landmark case of *Sidaway* (as will be discussed in Chapter three) – while most of them have been cleared up recently by *Montgomery*,¹⁰ - are still unresolved under current Saudi Arabian medical law as will be discussed throughout this thesis. The relatively slow changes to English law allow for in-depth analysis of the rationales for change – this also facilitates consideration of how, and how far, Saudi Arabian law may learn from the English experience.

The relative slowness of the development of English law regarding the standard of information disclosure cannot allow for in depth analysis of the justifications for change,

⁴ The Grand *Mufti* Abdulaziz ibn Baz was born in 1910 in Riyadh, where he was educated, further he held different positions such as a teacher, judge, university president and member of many national and international Islamic religious and academic institutions. He published many books and *fatawa*. He died from cancer in 1999. 'His Eminence Shaykh AbdulAziz ibn Abdullah ibn AbdulRahman ibn Muhammad ibn Abdullah Al Baz' GPSRI at <http://www.alifta.net/Fatawa/MoftyDetails.aspx?ID=2> (accessed 25/03/2015).

⁵ A brief of the *Mufti* lecture 'Rulers and scholars should be obeyed in virtue, because that would make stability' at <http://www.binbaz.org.sa/mat/8371> (accessed 29/03/2015) (Arabic).

⁶ See for example, M Gaudiosi 'Influence of the Islamic Law of WAQF on the Development of the Trust in England: The Case of Merton College' (1988) 136 *U. PA. L. REV.* 1231-1261.

⁷ A Yacoub *the Fiqh of Medicine Response in Islamic Jurisprudence to Development in Medical Science* (Taha Publishers Ltd 2001) p. 8.

⁸ *Ibid* p.111-112

⁹ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

¹⁰ See Chapter three for further discussion.

which further reflects on the relative dearth of Saudi law in this area. During the 30 years (since *Sidaway*¹¹ was decided) there have been significant English law cases and academic debates, discussions, analysing and criticising of the professional standard of care.¹² Such robust literature is the result of principled consideration of what patients (wherever they may be) what patients want and need, and of an increasing emphasis on protecting their rights and respecting their autonomy.¹³

That can be clearly understood from the decision in *Montgomery v Lanarkshire Health Board*.¹⁴ In this important case, the Supreme Court reinforced the importance of respect for patients' rights and autonomy, saying:

‘The social and legal developments which we have mentioned point away from a model of the relationship between the doctor and the patient based upon medical paternalism. They also point away from a model based upon a view of the patient as being entirely dependent on information provided by the doctor. What they point towards is an approach to the law which, instead of treating patients as placing themselves in the hands of their doctors (and then being prone to sue their doctors in the event of a disappointing outcome), treats them so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices.’¹⁵

While it is accepted that there may be problems associated with implementation of the changes proposed in this theses, based on the developments in English law, it is important to bear in mind that – with limited exceptions, such as in the case of refusal of life sustaining treatment – it is increasingly the case that the need to respect rights and autonomy in healthcare (along the lines of the recent English case law) is taking on increased significance in debates in Saudi Arabia.

Fourth, English law has a long history of dealing with the issue of recognising – in theory at least – the value of patient autonomy. The historical reluctance to focus on patients' rights rather than doctors' duties has contemporary relevance in Saudi Arabian medical law, providing a rich source of information and guidance on how laws can develop, based on principles which (as will be argued) are broadly similar between the jurisdictions (albeit with some differences which will be explored *infra*).

¹¹ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 AC 871.

¹² See Chapter three.

¹³ *Ibid.*

¹⁴ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

¹⁵ *Ibid.* para 81

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This relative newness of considering patient's rights and the extent to which it is protected in Saudi Arabia, was considered at a conference – the first of its kind - which was held in Riyadh (Saudi Arabia's capital) in 28-29 February 2016 under the title of 'The 1st Gulf Patient Rights Conference.'¹⁶ The mere holding of this Conference shows that the issue of patients' rights is receiving more attention and serious consideration in Saudi Arabia, suggesting that patients' autonomy and rights may become more central in the delivery of healthcare in the country.

Therefore, analysis of the well-developed English law approach to patients' rights can provide comprehensive and comparative views for current Saudi Arabian medical law, and can provide useful information as to how any deficiencies may be remedied. English law has numerous and rich ethical and legal literature which provides considerable information and will prove a very useful source of information for this study. Additional to the rich legal and academic heritage provided by judges and legal writers, the other benefit English law has as a comparator is the participation by different medical institutions, such as the Royal College of Surgeons, the British Medical Association and the General Medical Council *etc.*¹⁷ These institutions have conducted a considerable amount of work in establishing professional principles by collecting the legal principles and translating them in simple frames for professionals and patients. These can be seen in the different guidelines which have been published by these institutions and which provide useful extra-judicial guidance.

This wide variety of ethical and legal medical issues have been considered and discussed in depth in English law, in particular the principle of respect for autonomy and its relationship to consent to medical treatment and information disclosure. Hence, the study of English law may present options to deal with a variety of matters that have not been discussed yet under Saudi Arabian medical law. English law has largely dealt with the issues of consent and the standard of information disclosure in a medical context through case law, and there are extensive analyses and discussions about the relevant legal principles themselves, what issues judges have considered when developing and applying the law and the merits and disadvantages of different models of information disclosure. Study of this material will present a number of possible legal approaches to compare with Islamic *Sharia* and Saudi Arabian law. For example, both English and Saudi Arabian medical laws have made use of the concept of the professional (reasonable doctor) standard of care, as will be discussed.

¹⁶ For further information visit 'The 1st Gulf Patient Rights Conference' <http://gulfpatientrights.net/en/home-page> (accessed 15/02/2016)

¹⁷ See Chapters one and three.

Fifth, English law is a common law system which allows judges to interpret Acts and set precedents and legal principles when there is an area of ambiguity or deficiency, thus empowering courts to remedy some of the statutory gaps.¹⁸ Therefore, such a legal system can offer comprehensive analysis provided by judges in the field of respecting patients' autonomy and protection of rights. As will be discussed in Chapter four *Sharia* Medical Panels (SMPs) as medical courts in Saudi Arabia are only authorised to apply the law, so they are not permitted to go beyond the law or set a new legal principle, as the country does not apply precedents, except in rare cases and only by the Supreme courts as I will explain throughout this thesis. Again, this difference is a prime source of comparison and highlights the extent to which reception of laws is feasible, despite apparently different approaches. Saudi Arabia currently lacks the experience and history specifically in the area of giving more protection to patients' autonomy and rights as will be identified throughout this thesis. For example, the current Law of Practicing Healthcare Profession 2005 (LPHP2005) and Code of Ethics for Healthcare Practitioners 2013 (CEHP2013) are silent in regard to the amount of information and risk that should be disclosed; whether doctors should inform the patient about alternative available treatment options; the duty to answer patients' questions; the need to ensure that patients' understand the information given and the application of the therapeutic exception to withhold certain information. These legal vacuums still exist despite the fact that the medical regulations in Saudi Arabia have undergone some developments during the last three decades (as will be discussed in Chapters two and four). Therefore, LPHP2005 and CEHP2013 can still be characterised as underdeveloped regulations that lack the level of detail which is required in an effective legal instrument in the modern medico-legal climate. An example of that is the failure of both LPHP2005 and CEHP2013 to address the above issues.¹⁹ These deficiencies have created a considerable need to reconsider some aspects of the present Saudi Arabian laws as the current stance is capable of generating doubts among lawyers, patients and medical professionals about the legal rights and obligations arising in relation to information disclosure.

While the Saudi Arabian legal system has been to some extent influenced by other legal systems - an example has been highlighted by Hanson in his article 'The Influence of French Law on the Legal Development of Saudi Arabia'²⁰ where the author claimed that the Saudi Companies Law of 1965 has been influenced (coincide in some aspects) by French law²¹ –

¹⁸ G Slapper and D Kelly *The English Legal System* (9th ed Routledge.Cavendish 2009) p. 3.

¹⁹ See Chapter four for further discussion.

²⁰ M Hanson 'The Influence of French Law on the Legal Development of Saudi Arabia' (1987) 2(3) *Arab Law Quarterly* 272-291.

²¹ *Ibid* p. 290.

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there is no reason to believe that it cannot also benefit from analysis of other jurisdictions, such as English law. Of particular significance is that both the Saudi Arabian and the UK governments have recently signed a judicial memorandum of understanding in September 2014,²² which was approved by the Saudi Arabian government in April 2015.²³ This might suggest that if there is an official judicial agreement between Saudi Arabian and the UK governments, the influence of English legal principles and approaches may become increasingly important in the development of Saudi law, not least because there is a current agreement which allows cooperation with the English judicial system.²⁴ Additionally, given the long relationship between the UK and Saudi Arabia, in terms of political cooperation,²⁵ the historical link between these two countries, may be beneficial in terms of evaluating, and potentially adopting, some of the best practice from English law and applying this to reform the Saudi Arabian information disclosure standard.

Further, English law and Saudi Arabian laws share some common areas of legal principles. For example, the Saudi Arbitration Law 2012 (SAL2012) and English Arbitration Act 1996 (AA1996) have some similar aspects and principles one of which is related to what is called 'Consent Award or Award on Agreed Terms' where both article 45 SAL2012 and section 51 in AA1996 are alike and list the same principles.²⁶

Another example can be extracted from the new Saudi Companies Law 2015²⁷ (SCL2015) which seems to adopt and learn some principles from English Companies Act 2006 (CA2006). For example, SCL2015 and CA2006 coincide in relation to the establishment or formulation of a joint stock company by a single person. That was not allowed under the

²² 'Saudi Arabia and the UK ministers of justice signed a judicial memorandum of understanding' Saudi Press Agency <http://www.spa.gov.sa/viewstory.php?newsid=1271369> (accessed 15/02/2016) (Arabic)

²³ 'Saudi Arabian Councils of Ministers approved a judicial memorandum of understanding' Alriyadh newspaper <http://www.alriyadh.com/1041152> (accessed 15/02/2016) (Arabic).

²⁴ Ibid, Alriyadh newspaper stated that: 'The major features of this agreement is: 1. Both countries will strengthen the scope of judicial cooperation between them under the jurisdiction of the powers of each, according to the priorities of cooperation that they agreed for. 2. The two countries agreed to the development of cooperation in a number of areas, including: The exchange of publications, research and information relating to judicial systems and the administration of justice and the methods of the exercise of judicial work, and hold seminars and lectures with a view to sharing experiences and developments in the judicial field between the two countries, and work to promote cooperation in the training and transfer of professional legal experience between the legal experts of both countries to enhance the ability to exercise the legal profession on a global scale.'

²⁵ The UK and Saudi Arabia has a political relationship for more than 80 years 'When King Abdul Aziz met Churchill' <http://www.arabnews.com/node/213541> Arab News newspaper (accessed 15/02/2016). 'Bilateral relations with Saudi Arabia' <http://www.publications.parliament.uk/pa/cm201314/cmselect/cmfaff/88/8807.htm> the UK Parliament (accessed 15/02/2016)

²⁶ Z ALQurashi 'Grounds for Setting Aside Arbitral Awards Relating to Arbitration Agreement: A Comparative Analysis of Saudi and English Arbitration laws.' Vol11(1) *Majleat ALhooq* (2013) 334-386 p 354-356

²⁷ E Reda and R Bassi 'New Saudi Companies law' <https://www.dlapiper.com/en/saudi-arabia/insights/publications/2015/11/new-saudi-arabian-companies-law/> (accessed 28/09/2016)

annulled Saudi Companies Law 1965, but now under article 55 from SCL2015 it is permitted which is similar to CA 2006 section 7(1).²⁸

These examples demonstrate both that there are mutual areas and grounds between the two legal systems, and also that Saudi law has already learned from English law. Obviously, there are some clear differences in both legal systems²⁹ where a line cannot be crossed but these differences do not always mean that it is not possible or permissible to learn some lessons from each other especially with the recent judicial memorandum of understating signed between Saudi Arabia and the UK. Therefore, it is possible and not uncommon for Saudi Arabian law to absorb lessons from English law experiences where there is no conflict with basic Islamic principles. Indeed, there are aspects of law, I would argue potentially including respect for autonomy, where Saudi law shares more with English law than it does with some other non-Islamic jurisdictions

Therefore, this thesis will provide a comparison of how English and Saudi Arabian laws have dealt with the matter of information and risk disclosure standard in the context of medical treatment. This will enable a conclusion to be drawn as to whether specific reforms to Saudi Arabian medical law can and should be introduced by learning from the English law experience, and to recommendations based on this. The thesis therefore by doing that adopts a novel manner of reconsidering Saudi Arabian medical law by comparing it with a more developed legal approach to the same issues. Therefore, the thesis will be novel by pointing out the above legal deficiencies, comparing them to another legal system by emphasising on the notion of the principle of respect for autonomy to show how can be learnt from other experiences. This thesis will therefore contribute to the literature through its discussion and recommendations and it is hoped that it may assist Saudi Arabian lawmakers in considering reforms in this area.

Sixth, in apparent recognition of its actual and potential importance, English law is being taught in one of Saudi Arabian private universities (Dar-AlHekma University).³⁰ On the other hand, throughout Saudi Arabia, no other non-Islamic legal systems are taught in any educational institutions. This is a clear example showing that it is not only important to study English law in its home land and learn some lessons but also it is seen to be a relevant comparator in Saudi Arabia.

²⁸ See also article 71 section 1 from SCL2015 and section 175(6) from CA2006 which considered the same duty to avoid conflicts of interests in a joint stock company.

²⁹ Such as some aspects of criminal law for example, death penalty.

³⁰ A Rogowska 'English Law in Saudi Arabia' (27) *Arab Law Quarterly* (2013) 271-279

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Further, as Rogowska has argued, commercial arbitration is important in Saudi Arabia where there are many national and international investments and some (arbitral) legal disputes are decided in London, so it is obvious for Saudi students to learn both English language and law.³¹

This suggest that any research or comparative studies that include English law rather than other laws can be easily welcomed in Saudi Arabia So for this thesis to study and compare English law and argue that some lessons can be learnt that can be defendable, acceptable and familiar in Saudi Arabia where with other laws might not be.

On a more practical note, as my studies were undertaken in the United Kingdom, and as there are relatively few Scottish cases in this area, the best available resources to address the thesis's proposals and goals were related to English law.

English law has a rich heritage and accessible sources that can be traced and studied. Further, there are more sources which have discussed and studied the relationship between English law and Islamic and Saudi Arabian laws than any other non-Islamic law

This thesis will propose specific reform of Saudi Arabian medical law to provide greater recognition and protection of patients' rights to receive information about proposed treatment in order to give a sufficiently informed consent, but in a way that is in accordance with Islamic *Sharia* traditions. It will argue that it is important to make such legal changes by way of legislation in order to properly respect patients' autonomy.

1. An overview

Islamic *Sharia* was founded 1400 years ago and includes a combination of elements centred on religious faith. Most significant are the articles of faith of the religion and instruction on worship, such as requirements for prayer. However, because the religious principles concerned are regarded as fundamental and applicable to all areas of life, they also form the basis of legal requirements, which may be referred to as *Sharia* law. A country that applies Islamic *Sharia* is called an Islamic country. One such is Saudi Arabia, which has recognised the supremacy of Islamic *Sharia* as the main source of its laws. However, Saudi Arabia also has a legislative system. The procedure to set, amend and propose an act or adopt an international treaty or law in Saudi Arabia will be explained in Chapter two in this thesis, but it is worth giving a brief outline of it here before explaining its relationship with *Sharia* law.

³¹ Ibid. p 275-278.

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As Saudi Arabia is a monarchy country the King has the ultimate power (the King is both the head of the state and the prime minister),³² so by a Royal Order he can enact, annul and amend any acts without consulting the legislative authorities (the Council of Ministers and *Shura* (consultative) Council).³³ The Basic Law of Governance 1992 (BLG1992)³⁴ granted him that power.³⁵ For example, the late King Abdullah by a Royal Order in 2006 amended article 5 of the BLG1992, in relation to the rule of the succession, as the King established the Allegiance Commission, which according to its Act is responsible for the throne's succession.³⁶

The second way to legislate is through the *Shura* Council, which proposes a bill or an amendment. The proposal will be sent to the Council of Ministers for further discussion and consideration, and if an agreement is reached between both Councils, a Royal Decree will approve the act. If there is no agreement, the proposal will be sent back to the *Shura* Council for further consideration, and then it will return to the Council of Ministers. Then, if there is no agreement, the bill will be sent to the King for the final decision.

The third way is through the Council of Ministers, which has the power to propose a bill or amendment, with no need to send it to the *Shura* Council and the bill will be approved by a Royal Decree.

There are other legislative bodies which can participate in legislation: (1) General Presidency of Scholarly Research and *Ifta* (GPSRI), but its declarations must be adopted by the government to be an Act or part of it. (2) The Supreme Courts as the Law of the Judiciary 2007 (LJ2007) and Law of the Board of Grievances 2007 (LBG2007) give them the power to establish a general principle, which becomes legally binding to be applied by the lower courts.

The BLG1992 stated clearly that: 'Government in the Kingdom of Saudi Arabia derives its authority from the Book of God and the *Sunnah* of the Messenger, which are the ultimate

³² BLG1992 article 56, at <https://www.boe.gov.sa/ViewSystemDetails.aspx?lang=en&SystemID=4&VersionID=240> (accessed 12/09/2015).

³³ A Al-Fahad 'Ornamental Constitutionalism: The Saudi Basic Law of Governance' (2005) 30 *The Yale Journal of International Law* 375-396 p. 384-389.

³⁴ BLG1992 is factually and practically the Kingdom's constitutional law. It is based on Islamic *Sharia* and thus gives *Sharia* law supremacy.

³⁵ BLG1992 articles 44, 56 and 70.

³⁶ 'King Abdullah names members of the Allegiance Commission' the Royal Embassy of Saudi Arabia in Washington. At http://saudiembassy.net/latest_news/news12100801.aspx (accessed 20/05/2015).

sources of reference for this Law and the other laws of the State'.³⁷ Therefore, this obligation requires the Saudi Arabian lawmakers to form law in harmony with Islamic *Sharia*.

The thesis's major work is not to explain all elements of Islamic *Sharia* laws, but it will discuss the sources of Islamic *Sharia*, as this explains its origins. However, it is useful to provide in this Introduction a short outline of the forms of Islamic *Sharia* laws, such as the basis of a number of criminal offences, liability and punishment, the status of marriage and parenthood and a wide range of other areas such as inheritance, debt, trade, investment and so forth.

Some of these laws have been considerably developed over time through scholarship and practical application and contain a great deal of detail about the area they consider. For example, inheritance law has been set by the holy *Quran*³⁸ and the Messenger Mohammad³⁹ Peace and blessing be upon him (PBUH) traditions and Muslim scholars have paid great attention to seeking to understand and explain its principles and procedure. Inheritance law, has stated clearly who can inherit and how much and why he or she should inherit that share or percentage.⁴⁰ This approach is regarded as so settled that it has recently been able to be used in a computer program, where a person just needs to fill in the required information, and then the program will automatically determine the people who are entitled to the inheritance and their share.⁴¹

However, there are some aspects of Islamic *Sharia* law that have been less fully developed and, as a result, their application in a contemporary context is more open to interpretation. Many statements provide general principles that are required to be considered in specific contexts which either did not exist at the time of writing or which have undergone considerable change. There is reference to the practice of medicine in the Islamic *Sharia* but this thesis will argue that it is one of the areas that remain underdeveloped and its application to modern medical practice and the legal regulation of it has been unclear.

This thesis will therefore examine the Islamic *Sharia* perspective on medical practice because it is the foundational source of Saudi Arabian law, religious and ethical principles.

³⁷BLG1992 article 7. See also article 1 'The Kingdom of Saudi Arabia is a sovereign Arab Islamic State. Its religion is Islam. Its constitution is Almighty God's Book, The Holy Quran, and the Sunna (Tradition) of the Prophet (PBUH). Arabic is the language of the Kingdom. The City of Riyadh is the capital.'

³⁸ The holy *Quran* in translation (CH4: 11,12,13,14 and 176).

³⁹ Messenger Mohammad PBUH is the Muslims' and all nations' Messenger, he was born in Makkah in 571 and he became a Messenger in 610. He died in AlMadinah AlMunawwarah in 643. S AlMubarakpuri *The Sealed Nectar - Biography of the Noble Messenger* (Darussalam publisher 2002) p. 71, 86 and 558.

⁴⁰For example, A Hussian *the Islamic Law of Succession* (Darussalam 2005).

⁴¹ For example, the Saudi Arabia Ministry of Justice at <http://www.moj.gov.sa/arsa/courts/eforms/pages/mawarith.aspx> (accessed 22/03/2014).

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For this thesis to provide an appropriate understanding of the position of Islamic *Sharia* and of its influence on Saudi Arabian legislation, it needs to establish some general points of reference. Therefore, it will provide some background information about basic concepts and terminology, for example, the sources of Islamic *Sharia*: the holy *Quran*, the *Sunnah* and the method of interpretation through religious and legal scholarship.

In addition to *Sharia* Law, Saudi Arabia also has legislation that governs some areas of medical practice. The most relevant for the purpose of this thesis are the LPHP2005⁴² and the CEHP2013⁴³ which is also legally binding, as I will explain in Chapter two.

The focus of the thesis, therefore, is to examine Saudi Arabian and English law in order to identify whether there are any lessons to be learnt from English experience. Hence, the thesis will evaluate the development of the law in both jurisdictions and explore what it does and should be seeking to achieve. This will involve considering the ethical concepts of respect for autonomy and their origins in Western medical ethics and Islamic *Sharia* especially in the context of consent and information disclosure. The doctors' responsibility to provide good medical care has also played a large part in the approach to the practice of medicine in both countries and it has been explained in terms of patients being able and encouraged to trust in their medical providers.⁴⁴

However, concerns have been raised in the context of Western medicine that the element of trust leads to overly paternalistic behaviour by doctors and it will be argued that there has been a shift away from reliance on medical providers simply to act in the best interests of their patients and an expectation of a more equal partnership. It will be argued that the principle of respect for patient autonomy has become increasingly dominant in Western medical ethics and has replaced a more paternalistic approach. It will also be argued that this has been reflected in English law and that a professional practice based standard to information disclosure has been eroded so that one based more on the perspective of the rights of patients to information to make informed choices has been developed. While respect for autonomy is crucial, whether the legal standard could or should fully meet the ethical requirements for respect for autonomy will be considered.

⁴²LPHP2005 at <http://www.boe.gov.sa/ViewSystemDetails.aspx?lang=en&SystemID=164&VersionID=178#search1> (accessed 05/12/2014).

⁴³CEHP2013 issued by the SCHS. at <http://www.scfhs.org.sa/en/registration/ClassAndRegister/Reregister/Documents/Ethics%20for%20Health%20Practitioners.pdf> (accessed 12/09/2015).

⁴⁴For example, O'Neill *Autonomy and Trust in Bioethics* (1st ed CUP 2002) and M Khedhiri, A Adlan and M Abolfotouh 'Informed Consent in Clinical Care: Models of Patients' Satisfaction and Attitude Based on General Trust and Risks Disclosure' (2013) 46(2) *International Journal of Medicine and Medical Sciences*, 1171-1177.

By contrast, it will be argued that the approach in Saudi Arabia has continued to place more weight on the concept of trust in doctors rather than respect for autonomy and that this has influenced the development and application of legislation concerning medical law. While this approach may itself have rested on interpretation of Islamic *Sharia*, it will be suggested that *Sharia* law can in fact be interpreted in a way that is consistent with ensuring greater respect for patient autonomy. Presenting and analysing these different perspectives on the legal and ethical approaches to information disclosure allows an evaluation of which is a preferable way of approaching the issue and, although there may be no perfect solution, it will be proposed that some reform of Saudi Arabian legislation is warranted and would remain consistent with Islamic *Sharia* law.

In terms of the recommendations that this thesis will provide on reform of the current Saudi Arabian medical law position, they are therefore intended to achieve the following benefits: first and foremost they seek to protect patients' autonomy and change the culture to emphasise respect for patients' wishes and needs, but in a way that can be in harmony with Islamic *Sharia* teaching. Second, they seek to give doctors the confidence they need to practice medicine in an ethically and legally appropriate way by ensuring that their approach to seeking and obtaining consent to treatment adequately respects patients' autonomy.

Although the proposals for these recommendations are intended to be drawn from principles of Islamic *Sharia* law and to be compatible with it, Saudi Arabian legislative bodies have recently made it clear that the preferred route for legal development and reform is to enact legislation, as it has been contended that this would be easier to consider and apply.⁴⁵ This can be demonstrated in practice by a recent Royal Order that was issued in the beginning of 2015 to establish a committee that includes Saudi Arabian scholars and lawyers tasked with setting statutory laws in the areas that have no statutory laws.⁴⁶ This shows that the Saudi Arabian government is intending to form Islamic *Sharia* principles into statutory laws, clarifying certain areas and filling perceived gaps in coverage.

Hence, the approach of this thesis is to provide recommendations that may be of assistance to Saudi Arabian lawmakers when considering issues arising from allegations of inadequate information disclosure in medical treatment.

⁴⁵ For example, F Vogle *Studies in Islamic Law and Society, Islamic Law and Legal System: Studies of Saudi Arabia: Legal System of Saudi Arabia* (Brill Academic Pub 2008).

⁴⁶ Royal Order no A/20 in 2015. (Arabic)

It is also important to note that, although the Islamic *Sharia* is the principal source of Saudi Arabian laws, and all Saudi Arabian law must be consistent with it, that does not mean that it is a barrier that obstructs the further development of Saudi Arabian medical legislation. The Islamic *Sharia* itself cannot be changed, but the *Fiqh* (jurisprudence) and scholars' understandings are changeable because they rely on specific matters, times, and customs.⁴⁷ Accordingly, legislation passed in Saudi Arabia that is based on Islamic *Sharia* law is also able to be developed and reformed. Muslim scholars have dealt with some medical law issues in *Sharia*, but much of this scholarship was undertaken when the practice of medicine was not as complicated as it is now, and when information about risks, benefits and options for treatment were not as extensive. The need for patients to be involved in making treatment decisions was therefore arguably less significant than it is now. Accordingly, there are some general principles for matters that relate to medical law in *Sharia*, but these principles need to be extracted, collected, developed and reviewed to be put into practice in accordance with current medical issues.⁴⁸

This new perspective on Islamic *Sharia* and Saudi Arabian law, focusing on consent to medical treatment and information disclosure by comparing them to English law, makes this work novel as it provides examination of a little-researched topic in Saudi Arabian comparative jurisprudence. Further, this study will benefit non-Arabic readers who are interested in conducting comparative studies of medical law based on Islamic *Sharia*, Saudi Arabian and English law, by researching and providing basic references and sources. Recently a number of theses and studies in the area of Islamic *Sharia* and English medical law have been written in English.⁴⁹ This work will add a new subject to these resources. After completion of this thesis I intend to translate it into Arabic which then will provide both Arabic and English libraries with a comparative study of medical ethics, consent to medical treatment and information disclosure in the Saudi Arabian and English legal systems. It is hoped that it will encourage and support further comparative study, consideration and analysis of Saudi Arabian medical laws.

⁴⁷ A Yacoub *The Fiqh of Medicine Response in Islamic Jurisprudence to Development in Medical Science* p. 8.

⁴⁸ For example, M Ibn Qayyim Aljauziyah *Healing with the Medicine of the Prophet*, translated by J Abu al Rub. (Darussalam Publisher 2003).

⁴⁹ For examples, F Elgariani 'Al- Qawid al-Fiqhiyyah (Islamic Legal Maxims): Concept, Functions, History, Classifications and Application to Contemporary Medical Issues' a PhD thesis submitted to the University of Exeter in 2012, A Al-Hammadi 'Medicine, Medical Liability, and Doctors' Criminal Liability and Punishments in Islamic Sharia and the UAE' a PhD thesis submitted to the University of Exeter in 2004 and A Yacoub, 'The Fiqh of Medicine Response in Islamic Jurisprudence to Development in Medical Science' a PhD thesis submitted to the University of London in 2000. Which was published as a book in 2001.

2. The research method and the use of Islamic *Sharia*, Saudi Arabian legislation and Arabic language sources

The study will use a comparative, critical and analysis-based method of research using legal authorities, resources and commentaries relevant to the two jurisdictions. This thesis is concerned with the *Sunni* Islamic schools of thought on *Sharia* law. This should not be considered as showing disrespect towards other Islamic schools of thought but is due to the focus of this thesis being on Saudi Arabia, where the *Sunni* school predominates, as will be discussed in Chapter two.

Nevertheless, while there is a rich tradition of Islamic scholarship on *Sharia* law, compared with the array of materials available on the English legal position on medical treatment and information disclosure, there is a comparative shortage of Arabic language sources and materials, and even less those relating specifically to Saudi Arabia. The available materials in *Sharia* law that have a bearing on medical law are often not directly related to the topic of consent to medical treatment, and as noted, some were written a very long time ago, which leads to the observation that this is an area which is presently underdeveloped. It also lends itself to the need for *Sharia* law to be interpreted in a contemporary medical treatment context.

A matter to be explained is that there will be, in some places in this thesis, multiple uses of the same *Sharia* materials to illustrate different points. This is because the nature of the use and interpretation of Islamic *Sharia* requires such an approach. For example, the Messenger PBUH said: '[a]ny physician who practises medicine when he was not known as a practitioner before that and he harms (the patients) he will be held responsible.'⁵⁰ This prophetic statement can be cited to illustrate different points. Firstly, it can be used by scholars or lawyers to argue that, as the statement just included the liability of unqualified doctors, so those who are qualified should not be held liable if they make a medical error, because they are out of the statement's ambit.⁵¹ Secondly, it can be used to argue that a doctor may incur civil or criminal liability if either s/he is an ignorant in the way s/he conducts his/her practice or if s/he acts outside his/her own speciality, such as a family doctor who performs heart surgery.⁵²

⁵⁰ S Abi Dawud *Sunan Abi Dawud* at <http://sunnah.com/abudawud/41/94> (accessed 25/08/2015).

⁵¹ K Almshegeeh '*Tdamien Altabiabfe De AlshariaAlislamih* (Doctor's Liability in the Light of Islamic Law)' (2000) 6 *AlAdl* 1-23 p. 12-13 (Arabic).

⁵² M Ibn Qayyim Aljauziyah, *Healing with the Medicine of the Prophet*, p. 124.

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Therefore, it is common practice in Islamic scholarship to cite the same sources to support a number of different points and this method will be used in this thesis where required.

I have attempted not to cite Arabic language sources and to refer instead to English language materials as long as they address the same issues and provide sufficient information to cover the discussion of the issue. The reason for that is to give more reliability to the study by avoiding misconceptions of the ideas in the original sources in Arabic as there are some terminologies that do not have a synonym in the English language. However, some important sources are not officially available in English and the research for this thesis has required translation of some materials (books and journal articles) into English. This material I have translated myself, making every effort to ensure that the translation properly reflects the author's idea.

Further, in respect of Saudi Arabian statutory laws, I have where possible cited official translations into English, although even these may have some translation issues, which I will highlight where necessary - for example, the translation of an Act into English with the title: Law of Practicing Healthcare Profession 2005 which is provided by the Bureau of Experts at the Council of Ministers.⁵³ This might be more appropriately translated as the Law of the Practicing Healthcare Professions 2005. If there is no official translation of Saudi Arabian statutory laws, I have translated the Act's title and the relevant part of the Act myself. As with other Arabic language sources, I have sought to ensure that the translation reflects the original meaning of the Act. The materials obtained therefore provide coverage of both Islamic *Sharia* and Saudi Arabian medical law materials from the full range of available and accessible sources.

For clarity, I will only use the Gregorian year for the citation that is the equivalent to the year in *Hijri* calendar.⁵⁴ For example, citing a statutory law is a similar to an English law citation regarding the use of the title of the Act and date. For example,

Saudi Arabia: Law of Practicing Healthcare Profession 2005.

⁵³ At <http://www.boe.gov.sa/ViewSystemDetails.aspx?lang=en&SystemID=164&VersionID=178#search1> (accessed 05/12/2014).

⁵⁴ The official calendar of Saudi Arabia is the Islamic calendar (*Hijri* calendar). The *Hijri* calendar was set to start by the date when Messenger Mohammad PBUH emigrated to AlMadinah AlMunawwarah in A.D. 622. The *Hijri* calendar contains 12 months 354 or 355 days. The start and end of each of month relies on the beginning and end of the moon. Each month is either 29 or 30 and not fixed, which may change depends on the moon counting. Now we are in the year of 1436 which is 2015 by Gregorian calendar. S Abou-Samra 'Muslim calendar, Holy days and Festivals' in *Islamic Beliefs, Practices, and Cultures (Muslim World)* (Cavendish 2010) p. 151-174.

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On the other hand, whereas English law statutes are generally divided into parts, sections, subsections, paragraphs and subparagraphs, Saudi Arabian statutes are divided into parts, chapters, articles, sections and subsections. For example:

Saudi Arabia: Law of Practicing Healthcare Profession 2005, article 2, section B(1).

3. The thesis structure

Beside this Introduction, the thesis will be composed of four Chapters and a Concluding Chapter, as follows:

Chapter one

The Chapter will be used to provide the context for the argument that the principle of respect for autonomy has been a major factor in the development of the present legal approach to information disclosure and consent to medical treatment in England. Accordingly, Chapter one will discuss the concept of the principle of respect for personal autonomy and the approaches that have been taken to it in Western ethical literature, and in particular in Western medical ethics. The aim is to show how the ethical concept has developed in the context of medical treatment and the values that it seeks to protect in order to form a foundation for the analysis of the approach of English law. The Chapter will conclude that the principle of respect for autonomy would suggest full information disclosure of any matter that might affect the decision of a patient to proceed with medical treatment, although difficulties in achieving this will be acknowledged. An alternative approach, based on the principle of trust, will be considered, but will conclude that it has not assumed dominance in Western medical ethics as a foundation for the appropriate ethical approach to information disclosure and consent to treatment. One of the problems it has is that it may come into conflict with the principle of respect for autonomy and encourage overly paternalistic behaviour. Although some attempts have been made to meet this difficulty, it will be concluded that respect for patient autonomy is the major concept underpinning the Western ethical approach to information disclosure to patients. However, it will be suggested that full disclosure might pose difficulties if it were to be imposed as a legal standard and this will be discussed further in Chapter three.

Further, the Chapter will briefly present the sources and foundations of English law and how it is formed as well as its relation to ethics in general. As an aim to present how English law has considered ethics particularly in the area of consent and information disclosure, to examine that in Chapter three.

Chapter two

One of the main focuses of Chapter two is to present the sources of Islamic *Sharia*, to establish the foundation of Saudi Arabian medical ethics and laws. The Chapter also discuss if there is a common ground between Islamic *Sharia* English common law, by discussing whether there are some difficulties in Islamic *Sharia* adapting in line with English law. The Chapter will explain the Saudi Arabian sources of law and how the laws are formulated in the country and the influence of Islamic *Sharia* on its formulation.

The Chapter will explain that the standard of information disclosure to patients has not been stated by the primary sources of Islamic *Sharia*, so the issue has been opened for discussion and different interpretation by scholars and lawyers. However, there are a number of principles that are relevant to this discussion.

In terms of Islamic *Sharia* medical ethics, the Chapter bases its discussion on the idea that Islamic *Sharia* has a major concern about the maintaining of an individual's health, as it is taken as an important precept that a person should keep healthy and not cause any harm to his/her health or body or doing something against his/her faith. It is one of the general principles stated by the holy *Quran* that a person should not put him/herself in danger.⁵⁵

The Chapter will then consider the issue of respect for autonomy from the Islamic *Sharia* perspective and how that has been debated in Islamic *Sharia* medical ethical literature. The Chapter will point out that there are potential differences in the Islamic approach and understanding of the concept of autonomy which may have implications for considering the extent that patients' autonomy should be respected in relation to the provision of information as part of seeking consent to treatment. However, another general principle of Islamic *Sharia* is that Muslims should be trustworthy in general and the craft of medicine is considered to be one of the noble professions. Accordingly, those who practice it should be trustworthy, as they will be treating people who are likely to need to rely on their expertise. The notion of trust still plays a vital role in current medical practice, regulations and public general attitudes toward the doctor/patient relationship. It will be argued that the culture of Saudi Arabia has led to an approach to the interpretation of Islamic *Sharia* based more upon patients trusting their doctors than upon respect for autonomy.⁵⁶

⁵⁵ The holy *Quran* in translation (CH2:195).

⁵⁶ For example, A Adlan 'Informed Consent in Saudi Arabia' in R.G. Beran (ed.), *Legal and Forensic Medicine* (Springer-Verlag Berlin Heidelberg 2013) 893-907.

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While the primary sources of Islamic *Sharia* do not make specific reference to information disclosure in the context of medical treatment, nevertheless, the Chapter will come to the conclusion that respect for autonomy from an Islamic *Sharia* perspective can be used to support full information disclosure of any material fact that might affect the patient's decision whether to consent to medical treatment. This thesis would propose that full information disclosure based on the principle of respect for autonomy is an ideal ethical concept and it is compatible with Islamic *Sharia* medical ethics. While it would represent a shift in attitude to prioritise respect for autonomy over trust in the medical profession, it will be contended that this is justifiable and appropriate in a contemporary context.

Chapter three

The Chapter will examine how English law has developed its approach to consent to medical treatment in general and in respect of information disclosure and consent to treatment in respect of competent adult patients and the role of the judiciary in that process and the approach to expert evidence.

Chapter three will demonstrate the importance of patient consent and the consequences of not obtaining it. It will also consider how English law has drawn a distinction between a failure to provide adequate information disclosure which results in the absence of a legally valid consent to treatment, and where there has been a legally valid consent but the patient may bring a claim in negligence. It will be explained that the vast majority of claims concerning inadequate information disclosure are dealt with by the law relating to civil liability for negligence and this forms the main focus of further consideration in this Chapter. It will consider a number of models of information disclosure, that could form the basis for a legal test for adequate information disclosure. It will also examine how the legal approach has been influenced by the ethical principle of respect for autonomy discussed in Chapter one. This Chapter will also discuss the development of the professional standard of care in respect of information disclosure and the criticisms there have been of it as insufficient to adequately protect the principle of respect for autonomy. It will consider more recent developments that have been argued to provide greater respect for patient autonomy and whether there has been a move to a more patient based standard of information disclosure, as illustrated by the recent Supreme Court case of *Montgomery v Lanarkshire Health Board*.⁵⁷ The case has highlighted the importance of respecting the basic human rights of the patient in regard to self-determination.

⁵⁷*Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

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The Chapter will conclude whether the English legal approach does provide an adequate standard of information disclosure and whether there are reasons why the law could or should not provide a standard of full information disclosure. The conclusions reached will enable the English law approach to be compared and contrasted with the current Saudi Arabian medical law approach in Chapter four. It will form the foundation for the advice and recommendations that the thesis will propose for possible reforms to Saudi Arabian medical law based on lessons learned from English jurisdiction.

Chapter four

In this Chapter, the thesis will present how Saudi Arabian medical law has taken into account the ethical principles that have been set by Islamic *Sharia*, which the thesis discussed in Chapter two, in terms of patient consent and the standard of information disclosure. The aim is to highlight the areas that need to be resolved to provide a foundation to present advice and recommendations for law reform.

The Chapter will consider the legal consequence of the absence of a valid patient consent or the failure of adequate information disclosure. It will examine the current practice of applying the professional standard of care in terms of how much information and what risks should be disclosed. Further, the Chapter will explore the areas of deficiency in Saudi Arabian medical law in terms of the principle of respecting patient autonomy. In examining this issue, the thesis will consider more recent commentary that has been made by other researchers.⁵⁸

The Chapter will conclude that there is a legal deficiency in relation to the current Saudi Arabian professional standard of care for disclosure of information to patients as it fails to adequately ensure respect for patient autonomy in accordance with Islamic *Sharia*. This might have emerged because of the lack of the appreciation of the principle of respect for autonomy and the greater reliance on the notion of trust. A number of matters are currently unresolved. These include uncertainty over the amount of information and the type of risks that should be disclosed to competent adult patients; the doctors' legal duties to inform the patient about the available alternative treatments; the doctors' legal duty to answer the patients' questions and how they should be answered; whether doctors have a legal duty to

⁵⁸For example, M Abolfotouh and A Adlan. 'Quality of Informed Consent for Invasive Procedures in Central Saudi Arabia' (2012) 5 *International Journal of General Medicine* 269–275. B Jamjoom *et al* 'Attitudes Towards Informed Consent: A Comparison between Surgeons Working in Saudi Arabia and the United Kingdom' (2011) 26(1) *Oman Medical Journal* 29-33. H Al-Faleh *et al*. 'Detailed Disclosure to Saudi Arabian Patients on Risks Related to an Invasive Procedure' (2010) 31(7) *Saudi Med J* 814-818.

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ensure that the patient can understand the information provided; and the application of therapeutic privilege to withhold information.

However, the Chapter will conclude that the current professional standard of care undermines respect for the patient's autonomy and so it should be replaced by the prudent patient standard, which can be supported by Islamic *Sharia*. Saudi Arabian medical law reform must be compatible with Islamic *Sharia* and it has been argued that ensuring greater respect for patient autonomy is compatible with Islamic *Sharia*. These proposals will be set out in the Concluding Chapter.

Concluding Chapter

The Chapter will deliver recommendations for legal reform based on the discussion and analysis of the earlier discussions and arguments. These recommendations aim to ensure more legal recognition of a requirement to respect patients' autonomy but in a way that is in harmony with Islamic *Sharia* traditions. This would limit the reliance placed on medical expert evidence and change the role of the doctor in relation to providing information to patients. It is acknowledged that this would require a change to the culture in the provision of medicine but enshrining a more patient based standard of care in legislation would undoubtedly be an important step in achieving this.

As I have stated in this Introduction, it is permissible to learn from the experience of other legal systems so long as this does not conflict with the primary principles of Islamic *Sharia*, and this chapter will identify ways in which English law might inform Saudi Arabian law in this area in light of this important caveat.

These recommendations will include reconsidering the current professional standard of care to be in line with the prudent patient standard, and placing legal requirements on doctors to provide a certain level of information, including that relating to risk. Saudi Arabian medical law must place a legal duty on doctors to inform patients about the available alternative treatments and to answer patients' questions fully and truthfully. Further, a legal duty must be put on doctors to take all reasonable steps to seek to ensure that the patient can understand the information provided. Finally, the application of therapeutic privilege to withhold information should only be used in circumstances where the disclosure would cause serious harm to the patient, though it should not be used to prevent the patient from making an informed decision.

Chapter one: The principle of respect for autonomy and trust: a Western view

1. Preface

This Chapter aims to present Western perspectives on medical ethics, specifically the principle of respect for autonomy and its relationship to consent to treatment and information disclosure. It is chiefly focused on competent adult patients, as the thesis is limited to these categories of patients. It will also consider the notion of trust as an alternative or additional principle to respect for autonomy. The connection between consent and information disclosure with autonomy has been considered central in Western medical ethics.¹ It has also been said that the legal framework of consent and information disclosure for competent adult patients is grounded on the principle of respect for autonomy.² However, it can be suggested that trust has been recognised as an alternative model for regulating the ethical provision of medical treatment in Western medical ethics and as relevant to consent, and for that reason I will also consider it.³ Furthermore, while autonomy is recognised in Islamic *Sharia* (religious law) and Saudi Arabian medical ethics literature as an important principle, it will be suggested that trust has been likely to play a more significant role as a foundation of patients' care and the ethical and legal provision of treatment. This will be considered in Chapters three and four.

However, the main argument of this Chapter is to establish that respect for patients' autonomy is recognised as the primary ethical basis for providing information to patients when seeking their consent to treatment in Western medical ethics. It is this concept, rather than the notion of trust in the medical profession to provide necessary information, which has developed prominence. Respect for patient autonomy by the provision of full information to the patient about the proposed treatment will be suggested to be an ethical ideal. However, full information disclosure has practical limitations as a standard to be applied by the law for reasons that will be considered throughout this thesis.

¹For examples, S McLean *Autonomy, Consent and the Law* (1sted Routledge.Cavendish 2010), G Dworkin. *The Theory and Practice of Autonomy* (CUP 1988), T Beauchamp and J Childress *Principles of Biomedical Ethics* (7thed OUP 2013), A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge*. (1sted CUP 2009), J Coggon and J Miola 'Autonomy, Liberty, and Medical Decision-Making.' (2011) 17 *The Cambridge Law Journal*, 523-547, D Lawrence 'The Four Principles of Biomedical Ethics: A Foundation for Current Bioethical Debate' (2007) 14 *Journal of Chiropractic Humanities* 34-40, A Dawson and E Garrard 'In Defence of Moral Imperialism: Four Equal and Universal Prima Facie Principles' (2006) 32 *J Med Ethics* 200-204.

²Naik *Aet al.* 'Patient Autonomy for the Management of Chronic Conditions: A Two-Component Re-Conceptualization' (2009) 9(2) *The American Journal of Bioethics* 23-30.

³For example, O'Neill. *Autonomy and Trust in Bioethics* and M Hall 'Law, Medicine and Trust' (2002) 55(2) *Stanford Law Review* p. 463-527.

The conclusion of Chapter one will be considered in Chapter three as part of an examination of how far English law in fact protects the ethical concepts set out here and whether it goes far enough in doing so. Case law since the decision in the landmark case of *Sidaway v Bethlem Royal Hospital Governors*⁴ until the recently decided case of *Montgomery v Lanarkshire Health Board*⁵ will be examined. It will be argued that the law has progressively focused on the recognition of the ethical concept of respecting patient autonomy in information disclosure. However, while it provides some protection of competent adult patients' autonomy, it does not appear to require full information disclosure. Nonetheless, this thesis will argue that it goes further than present Saudi Arabian medical law, which will be discussed in Chapter four. The background to the development of this law based on the concepts of autonomy and trust in Islamic *Sharia* will be discussed in Chapter two. Whether there are reasons for a less protective legal approach to competent adult patients' autonomy in Saudi Arabia than in the UK, due to a different perspective on the concepts of autonomy and trust, will be considered. This will form the basis for making recommendations to reform the law on information disclosure in Saudi Arabia as part of seeking consent to medical treatment in the concluding Chapter.

This Chapter is divided into three main sections; the first will discuss the principle of respect for autonomy, the second will focus on the notion of trust. The third will briefly discuss how English law has developed and, as a general issue, its reliance on ethical principles. In order to contrast the approach taken to the development of law and the central place of ethical and religious principles in Saudi Arabia a brief overview will be given of relevant aspects of the English legal system.

2. The principle of respect for autonomy

The aim here will be to explain the importance that autonomy has assumed in Western medical ethics before examining in Chapter three the way in which the law has approached the issue of respect for autonomy through the principles of consent to treatment and, in particular, the requirement for information disclosure. The discussion in the following section will focus on the importance of autonomy to an individual by explaining what is understood by the Western concept of autonomy: what are its foundation and values? It will then turn to how autonomy is linked to consent and information disclosure.

⁴*Sidaway v Bethlem Royal Hospital Governors* [1985] 1 AC 871.

⁵*Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

2.1. A general overview of autonomy

The word autonomy, in its original sense, derives ‘from Greek *autonomia*, from *autonomos* having its own laws, from *autos* self [and] *nomos* law.’⁶ However, different understandings and definitions of the idea of autonomy have been noted.⁷ Dworkin, for example, has contended that it is unlikely that a ‘core meaning’⁸ of autonomy can be established. Nevertheless, there have been many attempts to consider what autonomy may include.⁹ Dworkin himself, for example, provided a list of what could be included, stating that autonomy ‘...is equated with dignity, integrity, individuality, independence, responsibility, and self-knowledge’.¹⁰ He then acknowledged that autonomy can also be ‘...identified with qualities of self-assertion, with critical reflection, with freedom from obligation.....’¹¹, and further added that autonomy ‘...is related to actions, to beliefs, to reasons for acting, to rules, to the will of other persons, to thoughts and to principles’.¹² To Dworkin’s lengthy list concerning the concept of autonomy, Faden and Beauchamp suggested that it may also contain ‘self-mastery, choosing freely, choosing one’s own moral position and accepting responsibility for one’s choice.’¹³ O’Neill adds again to Faden and Beauchamp’s suggestions with ‘self-control’ and ‘self-determination’.¹⁴ Nevertheless, despite Dworkin’s assertion of the difficulty on establishing a core meaning, there does appear to be a certain key concept and I would agree with MacLean that this can be understood by the etymology of the word autonomy.¹⁵ However, as the word autonomy came to be applied to individuals it transformed into the idea of ‘self-government’¹⁶ and therefore now at its heart ‘refers to the capacity for, or the right to, self-determination’.¹⁷ As Beauchamp and Childress noted, it is clear that being self-ruling and having freedom from control by others have been the crux of understanding autonomy.¹⁸

From what has been said, I would argue that most of the attempts to define autonomy ultimately focus on giving the person the power to make his/her own personal choice. Hence,

⁶ Oxford online dictionary at <http://www.oxforddictionaries.com/definition/english/autonomy?q=autonomy> (accessed 04/12/2014). See also A Duncan, G Dunstan and R Welbourn *Dictionary of Medical Ethics* (1sted Darton, Longman & Todd 1977) p. 212.

⁷ S Darwell ‘The Value of Autonomy and Autonomy of the Will’ (2006) 116(2) *Ethics* 263-284 p. 284.

⁸ G Dworkin *The Theory and Practice of Autonomy* p. 6.

⁹ A MacLean *Autonomy, Informed consent and Medical Law a Relational Challenge*. (1sted CUP 2009) p. 9.

¹⁰ G Dworkin *the Theory and Practice of Autonomy* p. 6.

¹¹ *Ibid.*

¹² *Ibid.*

¹³ R Faden and T Beauchamp *the History and Theory of Informed Consent* (OUP 1986) p. 7.

¹⁴ O O’Neill *Autonomy and Trust in Bioethics* p. 22.

¹⁵ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 10.

¹⁶ J Varelius ‘The Value of Autonomy in Medical Ethics’ (2006) 9 *Medicine, Health Care and Philosophy* 377-388 p. 377.

¹⁷ A Duncan, G Dunstan and R Welbourn *Dictionary of Medical Ethics* p. 212-213.

¹⁸ T Beauchamp and J Childress *Principles of Biomedical Ethics* p. 101-102.

it can be said that autonomy allows a person to base his/her actions and decisions on his/her wishes on how to live his/her life.¹⁹ Accordingly, it has been said that ‘to respect autonomy is to accept a person who has a right to hold views, make choices and take action based on personal values and beliefs’.²⁰ This makes us distinctive human beings, in charge of our personal affairs.²¹

It may be suggested that the concept of autonomy in Western ethics has been substantially developed based on the philosophical thoughts of two philosophers in particular: Immanuel Kant and John Stuart Mill.²² Their approaches to the concept of autonomy have been described as being a rational view (Kant) and a classic liberal view (Mill).²³ Kant wrote extensively on autonomy and in particular on the idea of ‘autonomy of will’.²⁴ He considered autonomy as ‘meaning the self-ruling of practical rationality’,²⁵ saying that ‘deliberated self-rule is a special attribute of all moral agents’.²⁶ Kant’s view is commonly used in discussions about the principle of respect for autonomy in ethical fields.²⁷ According to Kant’s theory of autonomy, in order to respect individuals’ right to self-determination everyone is required to ‘act so that you treat humanity whether in your own person or in that of another, always as an end and never as a means only’.²⁸ To this extent, then, autonomy is not about total individual freedom of choice and action: there are limitations on it, imposed by duties to respect others’ rights, including their right to autonomy. Accordingly, O’Neill understands Kant’s view on autonomy as follows:

‘Kantian autonomy is manifested in a life in which duties are met, in which there is respect for others and their rights, rather than in a life liberated from all bonds. For Kant autonomy is *not relational, not graduated, not a form of self-expression*; it is a matter of acting on certain sorts of principles, and specifically on principles of obligation.’²⁹ (Her emphasis).

¹⁹U Kihlborn ‘Autonomy and Negatively Informed Consent’ (2008) 34 *J Med Ethics* 146 -149 p. 146.

²⁰J Herring *Medical Law and Ethics* (5thed OUP 2014) p. 25.

²¹G Gillett ‘The Art of Medicine Autonomy and Selfishness’ (2008) 372 *The Lancet* 1214-1215 p. 1214.

²²M Donnelly *Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism*. (1sted CUP 2010) p. 16.

²³*Ibid* p. 17-21.

²⁴M Komrad ‘A Defence of Medical Paternalism: Maximising Patients’ Autonomy’ (1983) 9 *Journal of Medical Ethics* 38-44 at 38.

²⁵M Quante ‘In Defence of Personal Autonomy’ (2011) 37 *J Med Ethics* 597 –600 p. 597.

²⁶R Gillon ‘Medical Ethics: Four Principles Plus Attention to Scope’ (1994) 309 *BMJ* 184-188 p. 184-185.

²⁷M Komrad ‘A Defence of Medical Paternalism: Maximising Patients’ Autonomy’ p. 38.

²⁸J Azetsop and S Rennie ‘Principlism, Medical Individualism, and Health Promotion in Resource-Poor Countries: Can Autonomy-Based Bioethics Promote Social Justice and Population Health?’ (2010) 5(1) *Philosophy, Ethics, and Humanities in Medicine* at 1-10 p. 4.

²⁹O O’Neill *Autonomy and Trust in Bioethics* p. 83-84.

The liberal philosopher Mill in fact did not make use of the term ‘autonomy’ in his work.³⁰ Nevertheless, respect for autonomy can be seen as relevant to his view, which has been described as being akin to ‘the modern understanding of autonomy as the right to be self-governing...’.³¹ To represent this idea, Mill used the term ‘liberty’.³²

Mill considered a person’s liberty within a social agenda, so interference based on an individual’s ethical or physical good is not a sufficient justification.³³ Hence, for Mill: ‘The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. In the part that merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.’³⁴ Further, Mill held that respecting individual liberty has other benefits, such as allowing a person to develop his ability to think and act,³⁵ so that people can achieve happiness in their lives.³⁶ It therefore has a consequential or utilitarian value, which is often contrasted with Kant’s view which is seen as representing a more deontological approach.³⁷

2.2. Consequentialism/utilitarianism versus deontology

The ethical theory of consequentialism/utilitarianism emerged from the Bentham and Mill traditions and became an alternative ethical approach to one based on Christian theological approaches in the late eighteenth century.³⁸ The tradition of utilitarianism based on the notion that morality is not based on obeying religious obligations, but in the maximisation of people’s welfare and minimizing suffering.³⁹

The main focused of the consequentialists/utilitarians has been said to prompt the utility of a group of people over the individual.⁴⁰ However, consequentialists/utilitarians judge whether an action is ethically right or wrong based on its consequences; thus the action will be considered to be ethically correct if the outcome of it is ‘good’ otherwise it is a wrongful action because its outcome is ‘bad’.⁴¹ Thus, sacrificing the life of a person to save the lives of other four or five persons may be preferable ethically, because the outcome is ‘good’ for

³⁰ Ibid p. 30.

³¹ S McLean *Autonomy, Consent and the Law* p. 15-16.

³² Ibid p. 16.

³³ S Mill *On Liberty* (3rded London, 1864) p. 22.

³⁴ Ibid p. 22.

³⁵ Ibid p. 79-80.

³⁶ Ibid p. 83-84.

³⁷ J Driver *Ethics the Fundamentals* (1sted Blackwell 2006) p. 121-123

³⁸ T Beauchamp and J Childress *Principles of Biomedical Ethics* p. 354-355 and E Jackson *Medical Law Text, Cases and Materials* (3rded OUP 2013) p. 11.

³⁹ S Pattinson *Medical Law and Ethics* (3rded Sweet and Maxwell 2011) p. 6.

⁴⁰ J Driver *Ethics the Fundamentals* p. 40-41.

⁴¹ G Spielthener ‘Consequentialism or Deontology?’(2005) 33 (1-4) *Philosophia* 217-235 p. 219.

the greatest number of people.⁴² However, it should be noted that whether it is ethically preferable depends on whether allowing individuals to kill others to save lives leads to greater harms, such as lack of respect for human life, social disorder and so on. The critical point here is that it is weighing of the nature and severity of consequences and their potential for good or ill that is at the heart of the ethical decision-making approach.

A problem that emerges with consequentialism is what is meant by a 'good' outcome to regard the action being ethically justified. The Millian approach to consequentialism is focused on people's happiness, where it can be said that good is judged in relation to what would make people happy, so what makes more people more happy can be regarded as good.⁴³ However, that creates significant difficulties in making decisions because it would require that each person should be able to accurately judge the consequences of every decision or action. This would make the process of making a decision very difficult and complex in terms of seeking to verify whether the outcome is good or bad for each decision and whether the decision is ethically right or wrong.⁴⁴ It should also be noted that Mill limits liberty by application of the harm principle, which will be discussed later, but for the moment it is sufficient to note that while in general respect for individuals' liberty is regarded as likely to promote the greatest happiness to the greatest number of people, it may be limited where it is likely to significantly harm the liberties of others.

Another version of utilitarianism called 'rule utilitarianism' seeks to set general rules that would lead to the best consequences.⁴⁵ It has been said regarding rule utilitarianism that 'even if in the particular case following the rule will not produce the best outcome, if having the strict rule produces overall the best for society we should adopt it.'⁴⁶

Deontology can be defined based on its 'emphasis on moral rules, most often articulated in terms of *rights* and *duties*.'⁴⁷ (Original emphasis). The deontological ethical theory is based on the tradition of Kant.⁴⁸ It has its aim to prompt '...the interests of the individuals rather than the collective.'⁴⁹ However, for a Kantian approach to respecting an action, that action should be based on a ground that can be universalised so that it can be applied in all

⁴² M Crockett 'Models of Morality' (2013) 17(8) *Trends in Cognitive Sciences* 363-366 p. 363.

⁴³ S Mill *On Liberty* p. 83-84.

⁴⁴ J Herring *Medical Law and Ethics* p. 13.

⁴⁵ J Harsanyi 'Rule Utilitarianism and Decision Theory' (1976) 11(1) *Erkenntnis* 25-53 p. 30-33.

⁴⁶ J Herring *Medical Law and Ethics* p. 14.

⁴⁷ J Greene 'The Secret Joke of Kant's Soul' in T Nadelhoffer (ed.) *Moral Psychology: Historical and Contemporary Readings* (1st ed Wiley-Blackwell 2010) 359-373 p. 360.

⁴⁸ J Driver *Ethics the Fundamentals* p. 80.

⁴⁹ S Pattinson *Medical Law and Ethics* p. 7.

circumstances.⁵⁰ Thus, the person should ‘act in accordance with the universally valid moral principles that pass the requirements of the categorical imperative.’⁵¹ In consequence, it has been said that deontologists do not accept the ‘aggregative’ view of people’s interests; instead, they are ‘distributive’, as what is important to them is the duty that is owed, not the number of people involved.⁵²

A Kantian approach seems to dismiss the theory that is used by consequentialists to judge the morality of an action. For deontologists, evaluating the morality of an action, whether it is a good or bad, is based on the action itself and the set of rules relevant to it, irrespective of the circumstances or the consequences.⁵³ In this sense, it has been argued that the deontological theory is the negation of consequentialism theory.⁵⁴ Kant’s principle to treat the person as an end and not simply as a means can be applied to the example of killing a person to save others’ lives. For deontologists such an action would not be acceptable ethically as killing that person is considered as a treating him as means to an end.⁵⁵ Therefore, the justification that the consequentialists use to judge the ethicality of an action (the outcome), is for deontologists neither acceptable nor applicable, because for them, breaching an ethical principle cannot be justified by the outcome.⁵⁶

However, the deontological approach has been criticised by arguing that a refusal to consider the consequences of applying a principle in practice is not a good idea.⁵⁷ Relying on duties and rules in the belief that they are universalisable, may be problematic. For example, some of the rules that were accepted in Kant’s time may not be necessarily accepted today. Determining what rules must be followed or should be abandoned is difficult.⁵⁸ Other criticisms include how to resolve conflicts between ethical duties, which is in theory more straightforward for consequentialists, based on the best outcome.⁵⁹

In conclusion, there are valid criticisms of both the consequentialists/utilitarian and the deontological approaches to ethical decision-making. Nevertheless, in the following I will

⁵⁰ G Gaus ‘What is Deontology? Part Two: Reasons to Act’ (2001) 35 *the Journal of Value Inquiry* 179–193 p. 181.

⁵¹ S Sucher *the Moral Leader: Challenges, Tools and Insights: Challenges, Insights, and Tools* (1sted Routledge 2008) p. 191.

⁵² S Pattinson *Medical Law and Ethics* p. 7.

⁵³ M Crockett ‘Models of Morality’ p. 363

⁵⁴ G Spielthener ‘Consequentialism or Deontology?’ p. 221-222.

⁵⁵ J Herring *Medical Law and Ethics*. p. 15.

⁵⁶ C O’Gorman *et al.* ‘What is the Difference Between Deontological and Consequentialist Theories of Medical Ethics?’ (2013) 106(2) *Ir Med J* 15-16 p. 16.

⁵⁷ A Shakil ‘Kantian Duty Based (Deontological) Ethics’ at <http://sevenpillarsinstitute.org/morality-101/kantian-duty-based-deontological-ethics> (accessed 13/06/2015).

⁵⁸ J Herring *Medical Law and Ethics* p. 15.

⁵⁹ S Pattinson *Medical Law and Ethics* p. 9.

consider the value of autonomy based on both the Kantian and Millian traditions to show their significance in terms of the development of the notion of respect for autonomy as an ethical principle, and consider this specifically in the context of medical ethics. Despite the lack of consensus on which approach, if either, is correct, both these approaches may be seen to remain influential in medical ethics and also in informing the legal approach to information disclosure and consent to treatment.

2.3. The value of autonomy

In considering the value of autonomy, it has been suggested that it has both intrinsic and instrumental value.⁶⁰ Kant's and Mill's theories on autonomy (or liberty) can both be considered as relevant to these concepts. First, the intrinsic value of autonomy can be described as 'the value that autonomy has in itself or for its own sake, as opposed to it being valuable for the sake of something else'.⁶¹ Based on autonomy's intrinsic value, it can be argued that respect for autonomy is '...essential for the good life, rather than being valuable only insofar as it helps secure other valuable things'.⁶² The intrinsic value of autonomy can thus be understood as following from Kant's view as it has been stated that 'Kant claims that autonomy has such value that we should act in such a way so as to treat ourselves and others as an end, and never simply as a means to an end...'.⁶³

However, Young, for example, has argued that Mill's view can also be the basis for autonomy's intrinsic value.⁶⁴ As Darwall observed, '...a utilitarian can take the position that Mill seems to take, that personal autonomy is intrinsically beneficial to a person, that it is a constituent part of her well-being or happiness'.⁶⁵ Then Darwall went on to explain:

'This makes autonomy intrinsic to that which is intrinsically morally desirable, happiness or welfare, but not yet intrinsically morally worth promoting in itself. What makes an outcome intrinsically worth promoting from the moral point of view is still happiness or well-being; it is just that Mill believes that autonomy is an intrinsic part of that.'⁶⁶

It has also been argued that 'autonomy's value derives from its place within the matrix of our conception of what it is to be an interacting, responsible, principled, responsive human

⁶⁰ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 23. See also R Young 'The Value of Autonomy' (1982) 32(126) *The Philosophical Quarterly* 35-44 and S Darwall 'The Value of Autonomy and Autonomy of the Will'

⁶¹ J Varelius 'The Value of Autonomy in Medical Ethics' p. 378

⁶² T O'Shea 'Autonomy and Value' *Essex Autonomy Project Green Paper Report* (University of Essex: Essex Autonomy Project, 2011). at <http://autonomy.essex.ac.uk/autonomy-and-value> (accessed 31/12/2014).

⁶³ V Ashley, 'Philosophical Models of Autonomy,' *Essex Autonomy Project Green Paper Report*(University of Essex: Essex Autonomy Project, 2012) at <http://autonomy.essex.ac.uk/philosophical-models-of-autonomy> (accessed 31/12/2014).

⁶⁴ R Young 'The Value of Autonomy' p. 37.

⁶⁵ S Darwall 'The Value of Autonomy and Autonomy of the Will' p. 265-266.

⁶⁶ *Ibid* p. 266.

being'.⁶⁷ Further, it has been proposed that the role of autonomy in relation to a person's identity gives it intrinsic value, because it may promote the development of a person's character. It does so since autonomy allows people to set their goals, choose how to obtain them and how to behave towards other people, so autonomy is 'crucial to our self-definition'.⁶⁸ Young has also said that '[t]he exercise of personal autonomy is able to be seen as intrinsically desirable or valuable because of its foundational place for moral personhood and self-esteem, without its exercise on particular occasions being act-evaluatively for the best, or even for the good'.⁶⁹ In other words, even where the exercise of autonomy may be seen as producing unfortunate or harmful outcomes, it is 'good in itself' rather than depending for its own value on the result.

However, autonomy has also been regarded as having instrumental value and despite the point noted above that Mill's view can be used to support intrinsic value, it is perhaps more common to regard it as promoting the idea that respect for liberty (autonomy) is justified because it promotes other things of value.⁷⁰ The instrumental value of autonomy can be subdivided into two distinct values. The first is that, to respect a person's autonomy would in itself benefit the 'well-being' of people generally, and hence benefit the greatest number.⁷¹

The second, instrumental, value is that to treat a person as autonomous may encourage him or her to take responsibility for his or her actions and to hold obligations, by acting morally, which may benefit both the person himself and his/her community in general.⁷² It has accordingly been argued that to treat a person as if he/she has autonomy is valuable because those determined to respond to moral obligations will do so provided moral obligations exist. Thus, treating people as if they are autonomous may result in behaviour being modified in a way that is beneficial to the individual and the wider community.⁷³

It can be concluded that employing either an intrinsic value or an instrumental view of autonomy seems to give respect to the person to make decisions in way that reflects his/her individual needs and choice. However, this raises the issue of whether autonomy is an absolute right that must be respected by others in all circumstances or whether it has some limitations.

⁶⁷ H Levi *Respecting Patient Autonomy* (UIP 1999) p. 64.

⁶⁸ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge*. p. 26-27.

⁶⁹ R Young 'The Value of Autonomy' p. 43.

⁷⁰ S Darwall 'The Value of Autonomy and Autonomy of the Will' p. 265. See also S Mill *On Liberty* p. 57.

⁷¹ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge*. p. 27.

⁷² S Darwall 'The Value of Autonomy and Autonomy of the Will' p. 265-266.

⁷³ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge*. p. 25-26.

2.4. The limitation of autonomy and the principle of harm

Maclean has stated that: ‘If autonomy were to be seen as an absolute right to decide for oneself the consequence would be the risk of chaos with the vulnerable left to the mercy of the strong. In fact, if conceived as a right then it is logically impossible for it to be absolute.’⁷⁴

I would agree with this conclusion, since if there were to be an absolute right that each individual’s autonomy was respected and the wishes of individuals conflicted then, without reference to other principles, this right could not resolve disputes and they would likely be settled in accordance with power imbalances between the individuals. As we live in a non-isolated world and we interact and communicate with others, a claim that a person can enjoy an absolute right to autonomy is not defensible, because the person cannot do whatever he/she wants irrespective of others whose right to autonomy may be affected by his/her action. Therefore, autonomy has great value, but it must be subject to limitations. A key concept that has been used to place limitations on the extent of respect for an individual’s autonomy is therefore that of harm.

It has been argued that: ‘The requirement to respect autonomy ends where harm to others begins: we are not obliged to enable some to act in ways which compromise the interests of others.’⁷⁵ This argument for limiting respect for autonomy was encapsulated in Mill’s understanding of the harm principle, explained in his book *On Liberty*.⁷⁶ According to Mill’s understanding of individual liberty, noted earlier, a person can enjoy the right to act or make a decision regardless of whether others consider that choice to be ‘rational’ in the sense that Kant suggests. Instead, he provided justification for why self-harming or irrational decisions should nonetheless be respected, while at the same time restricting autonomy where it would result in harm to other people.

‘The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. 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 opinion of others, to do so would be wise, or even right.’⁷⁷

Hence, an autonomous decision that can be respected based on Mill’s approach is that which a competent person makes for him/herself, so long as it does not cause harm to others. Mill observed that: ‘The principle [of autonomy] requires liberty of taste and pursuits, of forming

⁷⁴ Ibid p. 29.

⁷⁵ M Jonas ‘Obesity, Autonomy and the Harm Principle’ (2010) 2(4) *Journal of Primary Health Care* 343-346 p. 343.

⁷⁶ S Mill *On Liberty* p. 22.

⁷⁷ Ibid.

the plan of our life to suit our own character; of doing as we like, subject to such consequences as may follow: without impediment from our fellow creatures, so long as what we do does no harm to them.’⁷⁸ This approach can be illustrated in Gorovitz’s observation:

‘No person is to be merely the instrument of another person’s plans; no person is to be treated in a manner that is blind to the plans, desires and values that are the fabric of his or her life and identity. Roughly speaking, we believe that it is obligatory to leave people alone, unless we have powerful reasons for not doing so’.⁷⁹

However, to apply the harm principle is not straightforward; for example it may not be easy to distinguish, even after a decision to take action has been made, whether harm has occurred or if that action is what has made the person’s situation case worse than it would have been.⁸⁰

It may be even more difficult to establish in advance what the outcome of a particular action will be. Further difficulties may arise in that in some cases a person’s action may seem likely to produce a harmful outcome without it being clear whether that outcome is a sufficient justification for intervention, because there will disagreement about whether the degree of harm anticipated is sufficient to warrant intervention to prevent it.⁸¹

Harm may be considered in terms of harms to other specific individuals or to the community. Feinberg, for example, has written extensively on the issue of whether and in what circumstances restricting the behaviour of individuals may be justified for the protection of society.⁸² This idea of protecting the community by limiting the principle of respect for autonomy might be applicable in term of public medical threats, for example to control the risk of spreading infectious disease. In such situations, an action of coercion or force might be justifiable to detain the infected person or treat him/her to prevent the spread of disease to others.⁸³ Hence, where the exercise of individual autonomy would cost the community too high, respect for autonomy may be overridden in consequence of the application of the harm principle.⁸⁴

Nonetheless, despite Mill’s justification for allowing self-harm in the exercise of personal autonomy,⁸⁵ an absolute acknowledgment of the right to autonomy might also be

⁷⁸ Ibid p. 26.

⁷⁹ S Gorovitz *Doctors' Dilemmas: Moral Conflict and Medical Care*. (Macmillan Pub Co 1982) p. 36-37.

⁸⁰ M Jonas ‘Obesity, Autonomy and the Harm Principle’ p. 343.

⁸¹ Ibid p. 343.

⁸² J Feinberg *Harm to Self (Moral Limits of the Criminal Law)* (1sted OUP 1986) p. 23.

⁸³ J Herring *Medical Law and Ethics* p. 94-95.

⁸⁴ A Wertheimer ‘(Why) Should We Require Consent to Participation in Research?’ (2014) 1(2) *Journal of Law and the Biosciences* 137–182 p. 146.

⁸⁵ English law seems to take Mill’s view see for example *Re T(Adult: Refusal of Medical Treatment)* [1993] Fam 95 p. 102 per Lord Donaldson ‘the right of choice is not limited to decisions which others might regard as sensible. It exists

controversial in relation to decisions concerning the person him/herself.⁸⁶ O'Neill for example has argued that some individual's action might be 'impulsive' or 'out of control',⁸⁷ thus a person may sometimes take a regrettable or reckless decision. Therefore, it has been contended that an individual's autonomy can be limited to prevent the person him/herself from self-harming behaviour.⁸⁸ Therefore, when there is an anticipated 'self-inflicted harm', violating respect for autonomy by taking a paternalistic approach to prevent that harm may be justified.⁸⁹ If a person does not meet the grounds for autonomous decision making, which will be considered briefly later, there may be greater justification for intervening to protect him/her from him/herself. However, this thesis is concerned with competent adults so the presumption will be in discussion that the person is capable of exercising autonomy. The extent to which paternalistic actions to protect a competent person from taking or making decisions that may be harmful to them will also be considered further later.

For the moment, however, it can be concluded that while autonomy has an obviously very significant value it is not absolutely protected, as the principle of harm may allow interference with a person's autonomy by limiting it, at least on the ground of preventing harm to others. Having outlined the principle of respect for autonomy and limitations on it in a broader philosophical context, it is now important to consider how the principle of respect for autonomy has been considered more specifically in the context of medical ethics and focusing on information disclosure and consent.

2.5. The notion of beneficence and the respect for autonomy in Western medical ethics

The principle of beneficence 'refers to a statement of moral obligation to act for the benefit of others.'⁹⁰ It has been observed that the principle of beneficence includes the following general rules: '1. Protect and defend the rights of others. 2. Prevent harm from occurring to others. 3. Remove conditions that will cause harm to others. 4. Help persons with disabilities. 5. Rescue persons in danger.'⁹¹ It may be justified from both a Kantian and a Millian perspective: as a rule that one should act to benefit others, and as an approach that seeks to provide the best outcome for the greatest number of people by acting to benefit others.

notwithstanding that the reasons for making the choice are rational, irrational, unknown or even nonexistent.' See also M Jiwa 'Autonomy: The Need for Limits' (1996) 22 *Journal of Medical Ethics* 340-343.

⁸⁶ For examples, S Engelbrecht 'Can Autonomy be Limited - an Ethical and Legal Perspective in a South African Context?' (2014) 32(1) *JFOS* 34-39 and T Rehbock 'Limits of Autonomy in Biomedical Ethics? Conceptual Clarifications' (2011) 20 *Cambridge Quarterly of Healthcare Ethics* 524-532.

⁸⁷ O'Neill *Autonomy and Trust in Bioethics* p. 28.

⁸⁸ H Hayry *The Limits of Medical Paternalism* (1st ed Routledge 1991) p. 25.

⁸⁹ *Ibid* p.67.

⁹⁰ T Beauchamp and J Childress *Principles of Biomedical Ethics* p. 203.

⁹¹ *Ibid* p. 204.

However, as will be discussed, it may be questioned whether one is indeed benefiting others if acting against their wishes and whether seeking to produce a good medical result by not respecting an individual's autonomy is the best outcome.

However, the principle of beneficence has a very long and close relationship with medical practice and it has been said that: 'The traditional goals of medicine are to preserve, protect and/or restore the patient's health.'⁹² The principle of beneficence shows the ancient idea of medicine and healthcare obligations. During the history of medicine, doctors' duties to care for their patients have been considered as the pledge of beneficence.⁹³ The principle of beneficence can be clearly seen in the Hippocratic tradition of medical ethics, stemming from the work of Hippocrates, the father of traditional medicine.⁹⁴ This tradition thus can be traced back to Ancient Greece, which is widely regarded as the birthplace of Western philosophy. The Hippocratic tradition was focused on the principle of beneficence as can be seen in a statement that directs the doctor to help patients and to not cause harm to them.⁹⁵ Doctors were also sworn to conduct their duties in their patients' best interests.⁹⁶

Ever since those days, the expression 'doctors know best' has been 'a watchword that not only acknowledges and endorses the physician's entitlement to power, but also implies the etiquette between doctor and patient that buttresses and validates that power.'⁹⁷ McLean has noted that this may reinforce the idea that duties of beneficence toward patients assume that doctors know what is good for patients, and that their goal is restoring health by selecting the appropriate medicine or medical procedure while ignoring the patient's wishes and views.⁹⁸

Indeed the Hippocratic tradition recognised the idea that physicians should bind themselves as follows: to 'perform [your duties] calmly and adroitly, concealing most things from the patient while you are attending him...turning his attention away from what is being done to him...revealing nothing of the patient's future or present condition'.⁹⁹ This suggests the

⁹² A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 50.

⁹³ T Beauchamp and J Childress *Principles of Biomedical Ethics* p. 214.

⁹⁴ Hippocrates was a Greek doctor and philosopher (BC460 – BC370). For further information about him and his works, J Pinault *Hippocratic Lives and Legends* (Birl 1992).

⁹⁵ T Beauchamp and J Childress *Principles of Biomedical Ethics* p. 214.

⁹⁶ Arguably, doctors are bound by the Hippocratic Oath and have promised to perform their profession ethically. It begins, 'I swear by Apollo the physician, and Asclepius, and Hygieia and Panacea and all the gods and goddesses as my witnesses... I will keep this Oath and this contract...I will use those dietary regimens which will benefit my patients according to my greatest ability and judgement, and I will do no harm or injustice to them' Greek medicine, Hippocratic Oath at http://www.nlm.nih.gov/hmd/greek/greek_oath.html (accessed 25/12/2014).

⁹⁷ L Furst *Between Doctors and Patients: The Changing Balance of Power*. (1st ed UPV 1998) p. 1.

⁹⁸ S McLean *Autonomy, Consent and the Law*. p. 9.

⁹⁹ Hippocrates, 'Oath of Hippocrates' in 1 *Hippocrates* 299-301(translated by WHS Jones) cited in E Jackson, *Medical Law Text, Cases and Materials* p. 166.

absence of recognition of a principle of respect for patients' autonomy in the sense of them being self-determining about their treatment, as patients were passively to surrender their care to their physicians and not to entertain any ideas of contradicting them.¹⁰⁰ Even if the doctor were to consult with the patient, the final treatment decision would be made by the doctor alone.¹⁰¹

Interpreted in this way, the principle of beneficence gives doctors, based on their medical judgement, the power to make decisions about treatment so that concerns for the patient's autonomy are dismissed or marginalised.¹⁰² Following on from the Hippocratic tradition that medical practitioners had a protective role to play towards their patients there was developed what has become known as the paternalistic approach to medical practice. It has been argued that: 'Paternalism centres on the notion that the physician...has better insight into the best interests of the patient than does the patient, or that the physician's obligations are such that he is impelled to do what is medically good, even if it is not 'good' in terms of the patient's own value system.'¹⁰³ Hence, paternalism, based on this view, has been said to represent the relationship between doctors and their patients until the latter part of the last century.¹⁰⁴

A paternalistic approach seems to allow a person's actions or decisions to be overridden for their own benefit.¹⁰⁵ It is important to note that benefit here is seen as being in respect of health outcomes for the patient. It has been said that if this approach is followed patients are likely to feel that their autonomy and choices, views, goals, and decisions are not respected or appreciated.¹⁰⁶ A duty based on the principle of beneficence (where beneficence is considered to be to provide the best medical outcome) may therefore be seen as being in conflict with a duty of respect for self-determination.¹⁰⁷ Veatch has commented that this has created 'a conflict between the old Hippocratic paternalism (having the physician do what he or she thought was best for the patient) and a principle of autonomy'.¹⁰⁸ However, although paternalism has been justified under the principle of beneficence it has been criticised. It has been suggested that a better view of the principle of beneficence is that it is one that takes account of the patient's views on what is in their best interests and obliges

¹⁰⁰ C Hawkins *Mishap or Malpractice?* (Blackwell 1985) p. 177.

¹⁰¹ J Harrington 'Privileging the Medical Norm: Liberalism, Self-Determination and Refusal of Treatment' (1996) 16 *Legal Studies* 348-367 p.349-350.

¹⁰² D Brock *Life and Death Philosophical Essays in Biomedical Ethics* (1st ed CUP 1993) p. 27.

¹⁰³ E Pellegrino and D Thomasma *For the Patient's Good the Restoration of Beneficence in Health Care* (OUP 1988) p. 7.

¹⁰⁴ M Donnelly *Consent: Bridging the Gap between Doctor and Patient* (CUP2003) p. 5-10.

¹⁰⁵ T Beauchamp and J Childress *Principles of Biomedical Ethics* p. 215.

¹⁰⁶ L Furst *Between Doctors and Patients: The Changing Balance of Power* p. 1 and 18.

¹⁰⁷ A Buchanan and D Brock *Deciding for Others: The Ethics of Surrogate Decision Making* (1st ed CUP 1989) p. 36.

¹⁰⁸ R Veatch 'Autonomy's Temporary Triumph' (1984) 14(5) *The Hastings Centre Report* 38-40 p. 38.

doctors to enter into discussion with the patient to obtain a consent to treatment.¹⁰⁹ As White and Seery have stated, ‘proponents of patient autonomy – and indeed society as a whole – stress the prime importance of letting the autonomous patient decide, by asserting that only patients can really decide what is in their best interests overall, as opposed to merely being in their medical best interests’.¹¹⁰ In other words, a doctor’s duty to promote the welfare of the patient not only consists of the duty to restore health but also to respect them as individuals capable of deciding what is best for them.

This approach would require that more respect should be paid to patients’ views and to facilitate their involvement in the medical decision. A paternalistic approach has been increasingly rejected, primarily because paternalism is seen as breaching patients’ personal rights most notably to respect for autonomy.¹¹¹ People may be believed to increasingly want the freedom to act, make free choices, and be independent. In our current climate, it seems to be accepted that the notion of freedom of choice and respect for patients’ autonomy should be supported.¹¹² Approaches that ignore the role of the individual in deciding whether to undertake proposed medical treatment based on what others consider would be for their benefit are treated with suspicion.¹¹³ Callahan has stated that:

‘In the context of medicine, it [autonomy] is a value that has served to establish the rights of patients over physicians, and the right to be spared the paternalistic interventions of those who think they understand my welfare better than I do. The purpose of autonomy is to make me my own moral master.’¹¹⁴

Arneson has observed that: ‘The consequences of coming to rely on the dispensation of paternalistic aid are mischievous, as are the consequences of dispensing paternalistic aid and the consequences of observing paternalistic aid dispensed to others.’¹¹⁵ In fact, Gillon has argued that respect for autonomy should be regarded as an essential principle in the field of medical ethics.¹¹⁶ Gillon justified this by suggesting that it has support from widely differing social or political positions; ‘autonomy is, then, *de facto* given a place of honour because the thrust of individualism, whether from the egalitarian left or the market oriented right, is to

¹⁰⁹E Pelligrino and D Thomasma *For the Patient’s Good The Restoration of Beneficence in Health Care* Chapter 4.

¹¹⁰ S White and J Seery ‘Consent: The Law and Ethical Consideration’ (2008) 10(3) *Anaesthesia and Intensive Care Medicine* 111-114 p. 112.

¹¹¹ R Veatch ‘Autonomy’s Temporary Triumph’ p. 38.

¹¹² M Siegler ‘The Progression of Medicine from Physician Paternalism to Patient Autonomy to Bureaucratic Parsimony’ (1985) 145 *Arch Intern Med* 713-715 p. 714.

¹¹³ S McLean *Autonomy, Consent and the Law* p. 7.

¹¹⁴ D Callahan ‘Autonomy: A Moral Good, Not a Moral Obsession’ (1984) 14(5) *the Hastings Centre Report*, 40-42 p. 40.

¹¹⁵ R Arneson ‘Mill versus Paternalism’ (1980) 90(4) *Ethics* 470- 489 p. 481.

¹¹⁶ R Gillon ‘Ethics Needs Principles—Four Can Encompass the Rest—and Respect for Autonomy Should be “First among Equals”’ (2003) 29 *J Med Ethics* 307-312 p. 311.

give people maximum liberty in devising their own lives and values'.¹¹⁷ It has been argued previously that the notion of respecting personal autonomy is based on the perceived ethical importance of a person's right to freedom and self-determination. Applying that to a patient's position '...respect for autonomy dictates that patients with decision-making ability have a right to voice their medical treatment preferences, and physicians have the concomitant duty to respect those preferences',¹¹⁸ which gives autonomy its value as a 'nurtured and promoted' principle.¹¹⁹ Simply, doctors cannot know every single detail about what would be in the patients' best interests, especially in connection with the patients' personal desires, needs, and beliefs, which will be different from one patient to another and obviously will also differ between patients and doctors. Therefore, 'physicians cannot and do not know enough about their patients' wants, needs, interests, hopes and fears to make decisions for them'.¹²⁰ Further, illness does not remove patients' basic rights; their rights to autonomy and free decision-making remain even if they may be in difficult circumstances and no one can override these rights as long as patients are competent adults.¹²¹

Based on the above discussions, it can be argued that the traditional Hippocratic approach to minimising the role of patients in taking decisions about their healthcare, due to doctors' special and superior knowledge in medicine, has been critically attacked. Speaking from a medical practitioner's perspective, Atkins has indicated that the preference for doctors to pay attention to the notion of the principle of respect for autonomy rather than paternalism is the need to 'accede to our fundamental fallibility and an epistemological humility.'¹²² As the focus on paternalism as being the sole or pre-eminent guiding principle in medical ethics has retreated, to be replaced by a greater emphasis on patient autonomy,¹²³ it is now expected that competent adult patients should have the final say regarding their healthcare decisions and doctors are usually no longer justified in simply acting on their patients' behalf in accordance with the doctor's view of what is best for them.¹²⁴

¹¹⁷Ibid p. 311.

¹¹⁸J Azetsop and S Rennie 'Principlism, Medical Individualism, and Health Promotion in Resource-poor Countries: Can Autonomy-based Bioethics Promote Social Justice and Population Health?' p. 2.

¹¹⁹Ibid p. 2.

¹²⁰G Weiss 'Paternalism Modernised' (1985) 11 *Journal of Medical Ethics* 184-187 p. 185.

¹²¹J Coy 'Autonomy-based Informed Consent: Ethical Implications for Non-compliance' (1998) 69 *Phys Ther* 826-833 p. 829. See also M Brazier 'Do No Harm—Do Patients have Responsibilities Too?' (2006) 65(2) *Cambridge Law Journal* 397-422 p. 406 and 422.

¹²²K Atkins 'Autonomy and the Subjective Character of Experiences'(2000) 17(1) *Journal of Applied Philosophy* 71-79 p. 75.

¹²³S McLean *Autonomy, Consent and the Law*. p. 7.

¹²⁴J Herring, *Medical Law and Ethics* p. 148.

2.6. Summary

Based on the above, it can be concluded that respect for the principle of autonomy is a central concept in Western philosophy and this has been increasingly recognised in medical practice. There has been a retreat from a paternalistic tradition in medical ethics and paternalism has been replaced by a recognition of the fundamental importance of patient autonomy. In the following discussion, the Chapter will consider the relationship between autonomy and consent to treatment. It will then discuss the requirements for a decision to be regarded as autonomous so that it can be relied upon and acted in accordance with by others. The main aim of discussing this is to demonstrate how the principle of respect for autonomy has led to the requirement for a competent adult patient to make a properly informed decision before consenting to (or rejecting) treatment.

2.7. Autonomy and consent to medical treatment

The importance of a competent adult patient's autonomy and of respect for it can be seen as central in Western healthcare. If to respect patients' autonomy is to allow them make decisions based on their values,¹²⁵ this requires patients to be enabled to properly consider the choices available, express those choices and have their decisions regarded as binding.¹²⁶

There is an obvious connection between respect for autonomy and seeking consent from a competent adult patient before medical treatment is undertaken. Consent¹²⁷ may be described as the expression of the patient's decision to accept recommended medical treatment, and is therefore the means for conveying the autonomous wish of the patient that is to be respected. It has been described more fully as follows: '[C]onsent means a voluntary, uncoerced decision, made by a sufficiently competent or autonomous person on the basis of adequate information and deliberation, to accept rather than reject some proposed course of action that will affect him or her.'¹²⁸

Therefore, broadly, there are three main elements to be considered for a patients' consent to be regarded as ethically valid: competence of the decision-maker, voluntariness in reaching the decision and adequate information disclosure before reaching the decision.¹²⁹

¹²⁵T Beauchamp and J Childress *Principles of Biomedical Ethics* p. 102-103.

¹²⁶ J Wilson 'Is Respect for Autonomy Defensible?' (2007) 33 *J Med Ethics* 353-356 p. 356.

¹²⁷ The topic of consent will be further discussed in Chapters three and four.

¹²⁸R Gillon *Philosophical Medical Ethics* (John Will & Sons 1986) p. 113.

¹²⁹ S Pattinson *Medical Law and Ethics* p. 115.

2.8. The autonomous decision

2.8.1. Competence of the decision-maker

As has been said in the Introduction to the thesis, the scope of this research is the competent adult patient, since particular issues arise when dealing with the treatment of children or those who are deemed to be incompetent by reason of illness or injury. Nonetheless, it is useful to briefly outline the conditions for a person to be deemed to have capacity to make decisions for themselves, since this sheds further light on the nature and importance of autonomy. Put simply, competence means that a person has the ability to undertake a task and perform that task.¹³⁰ The need for a patient to be deemed competent in order to rely on his or her decision has been significant in medical ethics.¹³¹ So, for example, it has been said that ‘the principle of respect for autonomy, simply stated, requires healthcare providers to allow *competent* patients to make their own healthcare decisions, based on their own values and goals.’¹³²(Emphasis added). According to Pattinson also, in his book *Medical Law and Ethics*, ‘for a patient’s decision to be truly autonomous it must be freely made with sufficient information and understanding’.¹³³ The assessment of a person’s capacity relies on the level of his or her ability to understand the information that has been provided to him/her in relation to the course of the treatment and the use of that information to arrive at a decision.¹³⁴ The patient can be regarded as having sufficient capacity if he/she can make his or her decision based on an adequate understanding of and ability to consider the information that has been provided.¹³⁵ A further practical issue is, of course, that a patient is able to effectively communicate his decision to the doctors. At its core, though, competence turns on the patient’s ability to receive and process information so that they can weigh it to arrive at a choice based on that information.¹³⁶

As noted, the scope of this thesis is the competent adult patient, so it will be assumed that the patients under consideration are deemed to have the necessary abilities to understand and weigh information to arrive at a decision. This focuses attention on the remaining elements for a decision to be regarded as sufficiently autonomous to be respected: voluntariness and

¹³⁰ E Baumgarten ‘The Concept of ‘Competence’ in Medical Ethics’ (1980) 6 *Journal of Medical Ethics*, 180-184 p. 180-181.

¹³¹ T Beauchamp and J Childress *Principles of Biomedical Ethics* p. 114

¹³² C Gauthier ‘The Virtue of Moral Responsibility and the Obligations of Patients’ (2005) 30 *Journal of Medicine and Philosophy*, 153–166 p. 156.

¹³³ S Pattinson *Medical Law and Ethics* p. 115.

¹³⁴ A Hirsch and B Gert ‘Ethics in Dental Practice’ (1982) 113(4) *JADA* 599-603 p. 599. See also E Baumgarten ‘The Concept of ‘Competence’ in Medical Ethics’.

¹³⁵ N Waller ‘The Psychological Structure of Patient Autonomy’ (2002) 11 *Cambridge Quarterly of Healthcare Ethics* 257-265 p. 262.

¹³⁶ S McLean *Autonomy, Consent and the Law*. p. 45-50.

information disclosure. Therefore, the following discussion will consider how these two aspects have been reflected on and the kinds of issues that arise in the context of medical treatment based on the principle of respect for autonomy.

2.8.2. Voluntariness in reaching the decision

The second element required for an autonomous decision has been stated by Faden and Beauchamp: 'Persons should be free to choose and act without controlling constraints imposed by others.'¹³⁷ It is also has been indicated that the main reason for and consequence of respecting our autonomy is to have the authority to not allow other to be involved in our affairs without our permission.¹³⁸

Therefore, respect for autonomy prioritises the idea that individual patients should be free to make personal, self-determining decisions without undue influence from another. In other words, a person's choice must represent his or her own decision, rather than being dictated by others.¹³⁹ This type of consideration in respect of patients can be seen in the statement by Delaney that 'respecting the autonomy of... a patient in a clinical context requires respecting the person as an equal; in particular acknowledging an equality in the ability to self-reflect and make choices'.¹⁴⁰

The question arises of whether the competent adult's decision can truly ever be regarded as his or her own and not subject to other influences and, if not, to what extent can it be considered as an autonomous decision?

It has been suggested that humans by their nature cannot ideally live in isolation as they are 'social animals', and that a person would not be a part of his or her society if he/she does not interact with it.¹⁴¹ Therefore, it is unlikely that a person would not be affected by the surrounding environment, people, religions, backgrounds and political systems.¹⁴² Dawkins has argued that humans may be programmed by genes,¹⁴³ but concedes that this would not necessarily mean that people cannot use their minds '...to depart from the dictates of the

¹³⁷ R Faden and T Beauchamp *A History and Theory of Informed Consent* p. 8.

¹³⁸ S McLean *Autonomy, Consent and the Law* p. 41.

¹³⁹ J Azetsop and S Rennie 'Principlism, Medical Individualism, and Health Promotion in Resource-poor Countries: Can Autonomy-based Bioethics Promote Social Justice and Population Health?' p. 2.

¹⁴⁰ C Delany 'Respecting Patient Autonomy and Obtaining their Informed Consent: Ethical Theory – Massing in Action' (2005) 91 *Physiotherapy* 197-203 p. 198.

¹⁴¹ Aristotle *Politics* (Translated by H Rackham) at

<http://www.perseus.tufts.edu/hopper/text?doc=Perseus:text:1999.01.0058> (accessed 11/12/2014).

¹⁴² J Prinz *Beyond Human Nature: How Culture and Experience Shape Our Lives* (1st ed Penguin 2012) p. 1-2.

¹⁴³ R Dawkins *the Selfish Gene* (30th anniversary ed OUP 2006) p. 46-56.

selfish genes and to build for ourselves a new kind of life...'¹⁴⁴ This is because even if it is accepted that genetic programming plays a significant part in a person's life, it is not 'fully deterministic', which suggests that a person can make a decision which has not already been programmed.¹⁴⁵ Nonetheless, although the issue regarding whether humans are already genetically programmed to make certain decisions and the extent to which they have their own free will to depart from that is interesting to discuss, not least because it casts some doubt on the concept of full exercise of autonomy (as it has been understood by the ethical theories described) as achievable in practice. However, it has not been considered central to discussion of medical ethics or law and this idea will not be considered further.

To examine whether autonomy is respected and the decision is made autonomously, it is more useful in the context of this thesis to consider three other types of suggested influences upon decision-making that may interfere with voluntariness:

2.8.2.1. Coercion

Coercion has been described as where a person has been subject to another person's intentional use of a credible and grave threat of harm that causes the first person's action to be controlled.¹⁴⁶ To be considered as credible, both the threatened person and the threat maker must believe that the threat can affect the threatened.¹⁴⁷ Alternatively, the threat maker must successfully be able to mislead the threatened person to believe that the threat can affect him or her.¹⁴⁸ Thus, for a patient to be considered to be coerced, the act of coercion must have its intention to put him/her under pressure to make a decision in a particular way and the threat must be credible, as mere perception in the patient's mind that he/she is being coerced cannot be considered as sufficient to establish that coercion has occurred.¹⁴⁹ However, if coercion is established, a decision made as a result of this influence that the patient would not otherwise have reached cannot be considered an autonomous decision.¹⁵⁰ Autonomy has been nullified by coercion.¹⁵¹ Even if the decision is informed, coercion invalidates it.¹⁵² Others have argued that exercising influence over another may be justified

¹⁴⁴ Questions and answers with R Dawkins, at <http://www.pbs.org/faithandreason/transcript/dawk-frame.html> (accessed 01/01/2015).

¹⁴⁵ Ibid.

¹⁴⁶ L Curzon and P Richards *The Longman Dictionary of Law* (7th ed Pearson Education Limited 2007) p. 102.

See also, R Faden and T Beauchamp *A History and Theory of Informed Consent* p. 339.

¹⁴⁷ T Beauchamp and J Childress *Principles of Biomedical Ethics* p. 138.

¹⁴⁸ R Faden and T Beauchamp *A History and Theory of Informed Consent* p. 339.

¹⁴⁹ Ibid. See also J Hawkins and E Emanuel 'Clarifying Confusions about Coercion' (2005) 35(5) *Hastings Center Report* 16-19

¹⁵⁰ T Beauchamp and J Childress *Principles of Biomedical Ethics* p. 138.

¹⁵¹ D Arnold 'Coercion and Moral Responsibility' (2001) 38(1) *American Philosophical Quarterly* 53-67 p. 56-59.

¹⁵² T Beauchamp and J Childress *Principles of Biomedical Ethics* p. 138.

in rare cases, even involving a degree of coercion.¹⁵³ However, I would agree with MacLean that a patient's decision must be taken '...in the absence of undue influence that attempts to control the patient's decision by unfairly exploiting the patient's weaknesses or vulnerability'.¹⁵⁴ Therefore, a person's decision should be free from coercion so as not to undermine respect for the patient's autonomy.

2.8.2.2. Persuasion

Persuasion may be said to take place when one person intentionally uses reasoning or arguments that make another person freely conduct or accept or believe something.¹⁵⁵ It has been argued that the decision made as a result of persuasion can be considered as autonomous,¹⁵⁶ because persuasion is not regarded as controlling.¹⁵⁷ Further, a decision that is grounded on persuasion is based on advancing reasons, choices and explanations to the decision-maker, who makes his own judgement.¹⁵⁸

Indeed, some would go further. Barilan and Weintraub have argued that '[a]biding by unexplored expressed wishes does not necessarily amount to respect for persons, since respect for persons is much more than submission to social boundaries'.¹⁵⁹ Instead, unlike coercion (which is not ethically acceptable), the act of persuasion has been suggested to be a 'basic human obligation'.¹⁶⁰ On this view, MacLean has argued that a 'positive strategy' to persuade is grounded on the idea that '...a true respect for autonomy requires more than simply abandoning patients to whatever choice they make'.¹⁶¹ Hence, respect for patients' autonomy may involve the use of persuasion provided that the communication of points of view and information still allows patients to make a decision for themselves.¹⁶² As it has been argued, '...if a physician wishes to act with respect for the person of his or her patient, the physician must participate in a conversation in which he or she will do his or her best to persuade the patient to consent, or to create a mutually agreeable compromise'.¹⁶³ Based on that, it can be said that for the patient to clearly consider what is in his/her own interests,

¹⁵³ Ibid p. 139-140.

¹⁵⁴ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 144.

¹⁵⁵ Oxford online dictionaries at <http://www.oxforddictionaries.com/> (accessed 08/01/2015).

¹⁵⁶ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p.85. See also, R Faden and T Beauchamp *A History and Theory of Informed Consent* p. 262.

¹⁵⁷ R Faden and T Beauchamp *A History and Theory of Informed Consent* p. 258.

¹⁵⁸ Ibid p. 262.

¹⁵⁹ Y Barilan and M Weintraub 'Persuasion as Respect for Persons: An Alternative View of Autonomy and of the Limits of Discourse.' (2001) 26(1) *Journal of Medicine and Philosophy* 13-33 p. 20.

¹⁶⁰ Ibid p. 21.

¹⁶¹ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 84-85.

¹⁶² A MacLean 'Autonomy, Consent and Persuasion' (2006) 13 *European Journal of Health Law* 321-338 p. 330-333.

¹⁶³ Y Barilan and M Weintraub 'Persuasion as Respect for Persons: An Alternative View of Autonomy and of the Limits of Discourse.' p. 20.

which s/he might not be clear about, may require persuasion and the participation of his doctor to make the decision plain for him/her.¹⁶⁴ Therefore, where the patient is not clear about what to choose, doctors can step in and give help in determining what is the most suitable decision.¹⁶⁵ Further, it might be ethically acceptable for doctors to persuade the patient towards a certain decision by highlighting any 'logical inconsistencies or irrational reasoning...where patients have formalised their goals but are mistaken in how best to achieve them.'¹⁶⁶ Thus, it can be said in such cases that the act of persuasion is ethically permitted¹⁶⁷ and may even become a duty that the doctor should undertake, if it assists the patient to make their own decisions based on what the patient wants.¹⁶⁸

2.8.2.3. Manipulation

Manipulation has been described as a kind of influence used on a person in a 'clever or unscrupulous way'.¹⁶⁹ It can be thought of as an influence that is neither coercive nor persuasive, but the manipulator wants another person to act in a particular way and believes that this will not happen if the person is left to make their own decision.¹⁷⁰ Therefore, manipulation can be a controlling act if the manipulator forces the person to submit to or reject something that the person himself does not really want. In other cases, it may be a non-controlling action, which can be considered more like persuasion.¹⁷¹ A clear example of manipulation, which is ethically unacceptable, is information manipulation. Not providing patients with information or lying to them or misleading them in a way that affects their belief about what treatment is appropriate for them would affect their ability to make a sufficiently autonomous decision.¹⁷² The manipulator may believe that a particular decision would be better for that person, so may have good intentions, but because the manipulator usually avoids the use of honest reasoning to persuade the other it has been said that 'there is something unsavoury about it [manipulation]...it is often self-serving and involves deception.'¹⁷³ Manipulation that includes the withholding of the information would abuse

¹⁶⁴ E Cassell 'The Nature of Suffering and the Goals of Medicine' (1982) 306(11) *N Engl J Med* 639-645.

¹⁶⁵ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 85.

¹⁶⁶ *Ibid* p. 85.

¹⁶⁷ D Smith and L Pettegrew 'Mutual Persuasion as a Model for Doctor-Patient Communication' (1986) 7(2)*Theoretical Medicine* 127-146 p. 143.

¹⁶⁸ R Faden and T Beauchamp *A History and Theory of Informed Consent* p. 346-348. See also A MacLean 'Autonomy, Consent and Persuasion' p. 337.

¹⁶⁹ Oxford online dictionaries at <http://www.oxforddictionaries.com/definition/english/manipulation?q+=Manipulation> (accessed 06/01/2015).

¹⁷⁰ J Rudinow 'Manipulation' (1978) 88(4) *Ethics* 338-347 p. 339.

¹⁷¹ R Faden and T Beauchamp *A History and Theory of Informed Consent* p. 258.

¹⁷² T Beauchamp and J Childress *Principles of Biomedical Ethics* p. 139.

¹⁷³ M Kligman and M Culver 'An Analysis of Interpersonal Manipulation' (1992) 17 *the Journal of Medicine and Philosophy* 173-197 p. 175.

the right of the other person to information hence that would undermine the person's autonomy.¹⁷⁴

In summary, voluntariness is regarded as an ethical requirement for a person's decision to be autonomous. It protects the patient's autonomy to make his/her own free decision. Persuasion can be ethically accepted, but it should be limited to just assisting the patient to make his/her own decision. On the other hand, the patient's autonomous decision must be free from coercion and manipulation, as that is ethically unacceptable and would undermine the respect for the patient's autonomy.

After having discussed the elements of competence and voluntariness and shown their importance to a patient's autonomous decision, the final requirement is of the greatest importance to this thesis: the requirement that the decision be based on adequate information for the patient to make his/her decision. Some aspects of the need for patients to have sufficient information to exercise choice have been mentioned already, but, in addition to concerns about manipulation of patients by withholding or misrepresenting information, the availability of information can be seen as significant in itself and therefore critical, even where there is no improper motive of the medical practitioner for not providing it. Thus, in the following the element of adequate information will be discussed.

2.8.3. Adequate information

There have been many ethical theories regarding the necessity for provision of appropriate medical information to the patient¹⁷⁵ (such as the notion of trust, as will be discussed later on), but I would agree with McLean that the most important among them is the principle of respect for autonomy, which places an ethical duty on the doctor to provide the patient with medical information to assist him/her to make a decision based on his/her own values and priorities.¹⁷⁶ It will be clear that enabling a patient to make a sufficiently autonomous decision requires information to be provided regarding his/her health condition and possible treatments for it and the implications of consenting to or refusing them.¹⁷⁷

In fact, throughout the history of medicine, consideration of information disclosure has been gradually developed from the Hippocratic tradition that advocated leaving patients in ignorance about medical information and their health conditions. As mentioned earlier, the general thrust of that approach appears to dissuade physicians from being open with their

¹⁷⁴ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 85-86.

¹⁷⁵ For example, S Pattinson *Medical Law and Ethics* p. 134-138.

¹⁷⁶ S McLean *A Patient's Right to Know Information Disclosure, the Doctor and the Law* (Dartmouth,1989) p. 6-8.

¹⁷⁷ S McLean *Autonomy, Consent and the Law* p. 42.

patients and may even lead them taking a decision on their patient's behalf.¹⁷⁸ It was argued that there has been a retreat from the dominance of paternalism as an accepted approach in medical practice in more recent times and an increased recognition of the importance of respect for patient autonomy in making decisions about their medical care.¹⁷⁹ However, this is not an entirely new approach and I would argue that, in the Western medical ethics heritage, there has been some prominent consideration of the matter of information disclosure; for example, Benjamin Rush,¹⁸⁰ a notable medical ethics philosopher writing in the 18th century, held that doctors should share medical information with their patients and deliver that information to the patients in a truthful way.¹⁸¹ John Gregory,¹⁸² another notable Scottish figure in medical ethics in the 18th century, also acknowledged the notion of doctors' duties to educate patients and the public to learn medicine; to be honest with their patients; to use and apply proper methods to tell their patients about their cases; and to use an appropriate manner to break the news to patients when their health was in a critical situation.¹⁸³ This approach places emphasis on the patients' need to be provided with information to make their decisions. It can clearly be argued that an autonomous decision relies on the prior sharing of relevant information, and accordingly in order to respect autonomy, that doctors should be under a duty to provide it. Accordingly, this view rejects the idea of paternalism being exercised by doctors as sole determiners of whether treatment is given and instead places greater priority on respect for patient autonomy.¹⁸⁴ To respect patients' autonomy is to allow them to be in charge of their decision-making (subject to caveats regarding the clinical appropriateness of treatment and resource constraints).¹⁸⁵ In fact, it has been argued that in our modern society it becomes difficult to not rely on sufficient information that would be given to us by experts as we cannot properly make a decision without access to specialist knowledge.¹⁸⁶ Therefore, it follows that doctors have a similar

¹⁷⁸ L Furst *Between Doctors and Patients the Changing Balance of Power* p. 1-18.

¹⁷⁹ For example, E Sakellari 'Patient's Autonomy and Informed Consent'(2003) 13 *Icus Nurs Web J* 1-9 and G Steevenson 'Informed Consent' (2006) 16(8) *JPP* 384-388.

¹⁸⁰ For further information about Benjamin Rush see, C Burns 'Setting the Stage: Moral Philosophy, Benjamin Rush and Medical Ethics in the United States before 1846' in R Bake (eds.) *The American Medical Ethics Revolution: How the AMA's Code of Ethics Has Transformed Physicians' Relationships to Patients, Professionals, and Scarcity.*(JHUP 1999) p.3-16.

¹⁸¹ R Faden and T Beauchamp *A History and Theory of Informed Consent* p. 66-65

¹⁸² For further information about John Gregory see, M Stratling 'John Gregory (1724-1773) and his Lectures on the Duties and Qualifications of a Physician Establishing Modern Medical Ethics on the Base of the Moral Philosophy and the Theory of Science of the Empiric British Enlightenment' (1997) 9(3) *Med Secoli J* 455-475.

¹⁸³ J Gregory *Lectures on the Duties and Qualifications of a Physician* (M. Carey & Son 1817) p. 33-37.

¹⁸⁴ S McLean *Autonomy, Consent and the Law* p. 42.

¹⁸⁵ E Sakellari 'Patient's Autonomy and Informed Consent' p. 2.

¹⁸⁶ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 43.

duty, so a failure to do so with intention or not would lead to ‘a false reliance that undermines the individual’s autonomy’.¹⁸⁷

Hence, information is essential to patients’ decisions, but the question here is what kind of information should be provided to them? There is a continuing debate over the amount and type of information that should be given to patients and there is no clear answer, as it would not be easy to satisfy everyone about what should be disclosed. McLean, for example, has proposed that:

‘While it could be argued that only full and complete disclosure would allow for an autonomous decision to be made, in practice this would likely prove impossible and, some would argue, may even be counter-productive. It is increasingly recognised that demanding full disclosure of every piece of information within the healthcare professional’s knowledge would be unreasonable and even potentially unhelpful’.¹⁸⁸

Waller also shares this concern, with which I agree, that to give an enormous amount of information to the patient which he cannot understand and absorb would not empower the patient to be in charge of his decision.¹⁸⁹

Although information is fundamental to the patient’s autonomous decision there may be information that is not helpful or necessary for the patient to know, such as all the details of a medical procedure.¹⁹⁰ This is because knowing the exact details of how a procedure will be performed is important for the person who will conduct it, but it is not necessarily needed for the person to whom it will be applied in order to agree to it.¹⁹¹ MacLean has given the following example to stress the point ‘it is completely unnecessary for patients to know that a purse-string suture is employed to close the defect left when an appendix is excised.’¹⁹² Indeed, such information may tend to confuse or mislead the patient and might negatively affect the patient’s decision, because the patient may pay more attention to the details of the procedure and less attention to the information that he really should consider in making his decision. Another type of information which may not be helpful to disclose to the patient ‘is details of the scientific evidence in support of the procedure.’¹⁹³ The patient might need to know that there is research that has indicated that procedure A is better and more effective

¹⁸⁷ *ibid.*

¹⁸⁸ S McLean *Autonomy, Consent and the Law* p. 44.

¹⁸⁹ N Waller ‘The Psychological Structure of Patient Autonomy’ p. 262.

¹⁹⁰ N Manson and O’Neil *Rethinking Informed Consent in Bioethics* (1st ed CUP 2007) p. 16.

¹⁹¹ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 135.

¹⁹² *ibid.*

¹⁹³ *ibid.*

than procedure B; on the other hand, the patient does not necessarily need to know or understand how the research demonstrated that.¹⁹⁴

Another argument suggests that there would be difficulty if ‘full knowledge’¹⁹⁵ was a prerequisite for considering the decision as autonomous, as it has been said that requiring full knowledge before a person could be deemed to be making an autonomous decision is ‘just a means of limiting action: sometimes an underhand means. No one has perfect knowledge, and a demand for it permits those with power to close in when a person is trying to make an unusual decision.’¹⁹⁶

Hence, it seems that from an ethical point of view a standard of full disclosure of information concerning proposed options for the care of a patient might at first sight be an ideal position, since it would ensure that all information available was given to the patient. However, it seems to not be an achievable or even necessarily a desirable standard for the reasons given. So, the question is; is there an approach under which it is easier to satisfy an individual patient’s relevant information needs than to require complete and full disclosure of all available information?

There have been different suggestions to find an alternative ethical standard for disclosing information, which may better satisfy the patient’s need for information, and in the following I will consider some standards that have been proposed.

O’Neill has agreed that full information disclosure is a problematic matter, and has asserted that this is not defensible or achievable.¹⁹⁷ She has suggested that:

‘At best we may hope that consent given by patients in the maturity of their faculties, although not based on full information, will be based on reasonably honest and not radically or materially incomplete accounts of intended treatment, and that patients understand these accounts and their more central implications and consequences to a reasonable degree.’¹⁹⁸

O’Neill then associated her suggestion of information disclosure to the idea of a patient-doctor participation and trust relationship as forming the basis for providing information.¹⁹⁹

However, I would suggest this has difficulties, as it may be seen as implementing and

¹⁹⁴ Ibid.

¹⁹⁵ J Coggon ‘Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?’ (2007) 15 *Health Care Anal* 235–255 p. 245.

¹⁹⁶ Ibid.

¹⁹⁷ O’Neill *Autonomy and Trust in Bioethics* p. 44.

¹⁹⁸ Ibid.

¹⁹⁹ Ibid.

supporting the paternalistic doctor relationship, which, as I argued above, would undermine respect for patient autonomy. This option, to rely on the notion of trust is a difficult standard to be adopted by law also since would also raise practical difficulties as to how the law could enforce it. I will revisit O'Neill's argument and consider it further later in this Chapter when examining the concept of trust in more detail.

Another alternative to full disclosure has been suggested that, rather than setting out particular rules about disclosing certain amounts or types of information, proposes that the emphasis should be on what would help the individual patient make a sufficiently informed, and hence autonomous, decision:

‘...meeting a person’s individual needs for information and choice based on a deeper understanding of their autonomy means that rules and procedures of communication become less important than adoption of attitudes of respect, curiosity and concern to find out about the patient’s needs, capacities and preferences.’²⁰⁰

Therefore, the disclosure of information required is the information and knowledge that is likely to be relevant to a particular patient’s conditions and in relation to their own choices and decisions.²⁰¹ This would involve a more active role for doctors in determining the information needs of patients rather than viewing themselves merely as passive providers of medical knowledge. Patients must be given relevant information about their health conditions and be actively encouraged to seek information, accepting the responsibility to ‘participate in the informed consent process’²⁰² by conversing with the physicians, sharing information and asking questions in order to comprehend any unclear information.

What this approach also suggests is that to just provide patients with information with no understanding by them would arguably make their decision not a sufficiently autonomous one, as McLean has described such a decision as ‘impaired’.²⁰³ Waller has also argued that ‘[i]nformation is an important element of autonomous control; but unless the patient has confidence and competence to understand, it provokes stress rather than providing comfort.’²⁰⁴ Therefore, for a decision to be regarded as an autonomous, it should be grounded on understandable and clear information.²⁰⁵ For patients to be said to have understood information that relates to their health condition, it has been said that they should at least

²⁰⁰ C Delany ‘Respecting Patient Autonomy and Obtaining their Informed Consent: Ethical Theory – Massing in Action’ p. 201-202.

²⁰¹ S McLean and J Mason *Legal and Ethical Aspects of Healthcare* (1st ed GMM 2003) p. 47.

²⁰² C Gauthier ‘The Virtue of Moral Responsibility in Healthcare Decision-Making’ p. 276.

²⁰³ S McLean *Autonomy, Consent and the Law* p. 46.

²⁰⁴ N Waller ‘The Psychological Structure of Patient Autonomy’ p. 262.

²⁰⁵ R Faden and T Beauchamp *A History and Theory of Informed Consent* p. 248-249.

understand what health professionals would think necessary as a requirement to agree to or refuse the proposed medical treatment.²⁰⁶ However, more than that, it has been suggested that the information that is provided to the patient should be based on his/her views and values as well as conveying information on the consequences of the treatment, in order to help patient understanding.²⁰⁷

Beauchamp and Childress have recommended that information should be provided in simple language and using simple explanations that the patients can understand.²⁰⁸ This approach has a support in medical practice, and it has been said that a doctor should use clear statements to explain the risks involved in the medical treatment or procedure by using percentages or written information with clear examples in order to present the risks in an understandable way.²⁰⁹ Patients' understanding can be enhanced, as above-mentioned, through involvement and communication between doctors and their patients, so that patients are actively engaged in discussion about treatment options rather than passive recipients of information.²¹⁰

Nonetheless, it would be ethically ideal to place a duty on a doctor to ensure that the patient has understood the information given, but that is not possible in practice. It has been observed that there is an 'epistemological aspect' to ensuring that a patient has understood the information, which has been provided to him/her.²¹¹ The issue is that, if a patient has given consent and signed a consent form, that may be taken to indicate that the patient has in fact understood the information with no more assessment being made of his/her understanding.²¹² In other words, mere transmission of information and agreement does not necessarily mean that the patient has understood. In fact, it may be impossible to ensure that a patient has understood even given the best and clearest explanations.

Thus, in conclusion I would agree with the suggestion that what can be aimed at instead is to ensure that doctors make the effort to ensure so far as possible that patients have understood by communicating with their patients and engaging in a clear discussion and explanation. The aim is to leave the patient free to make a decision that reflects his/her values

²⁰⁶T Beauchamp and J Childress *Principles of Biomedical Ethics* p. 131-134.

²⁰⁷J Kennedy "'Doc, Tell me What I Need to Know"—a Doctor's Perspective' (2003) 317 *BMJ* 862-863 p. 862.

²⁰⁸T Beauchamp and J Childress *Principles of Biomedical Ethics* p. 131-134

²⁰⁹S Graham and J Brookey 'Do Patients Understand?' (2008) 12(3) *the Permanente Journal* 67-69 p. 68.

²¹⁰R Kukla 'How Do Patients Know?' (2007) 37(5) *The Hastings Center Report* 27-35 p. 28-28.

²¹¹J Hutton and R Ashcroft 'Some Popular Versions of Uninformed Consent' (2000) 8 *Health Care Analysis* 41-52 p. 45.

²¹²Ibid.

and interests in the light of the adequate information that has been provided,²¹³ as that can be applied and achieved by the law, as I will discuss in Chapter three.

Therefore, this thesis is not in favour of adopting the stance that to satisfy the ethical principle of respect for autonomy it is necessary for there to be full information disclosure, in the sense of disclosing all possible information about a patient's condition and options for treatment, for the reasons that have been stated. Instead, it is concluded that sufficient information is necessary for competent adult patients to be self-determining and to respect their autonomy. The kind of information that might reasonably be expected to be included would cover diagnosis, prognosis, proposed treatments and their risks and benefits as well as the available alternative options for treatment. This information should be presented in a way that so far as possible enables the fullest understanding of the patient. Thus, I would suggest that a doctor will be under an ethical duty to supply the patient with sufficient information which is clear, can be understood and reflects the patient's values, needs and desires. It can be said that giving such information to the patient shows respect for his autonomy, choices and wishes.²¹⁴

The standard of information disclosure that should be set should follow from this and Chapter three will consider to what extent this standard has been met by UK law, in order to examine how has English law considered it in its development for consent law and the standard of information disclosure in the light of Western medical ethics. Specifically, the recognition of the principle of respect for patient autonomy.

While this is the approach that will be advocated in this thesis, a further important issue remains to be considered: whether the doctor may decide to withhold information and not discuss some issues concerning the patient's condition or treatment. If the notion of respect for patients' autonomy assumes that patients must be fully informed²¹⁵ it can be argued that withholding information that is relevant to patients' decision-making would appear to be contrary to the idea of respect for patient autonomy.²¹⁶

However, as discussed previously, there is a distinction between providing all information available and providing information that is relevant and useful to patient choice. Based on

²¹³ S McLean *Autonomy, Consent and the Law* p. 50-51.

²¹⁴ E Pellegrino and D Thomasma *For the Patient's Good: The Restoration of Beneficence in Healthcare* p. 23-25.

²¹⁵ For example, C Williamson 'Withholding Policies from Patients Restricts their Autonomy' (2005) 331 *BMJ* 1078-1080, D Sokol 'Truth-Telling in the Doctor-Patient Relationship: A Case Analysis' (2006) 1(3) *Clinical Ethics* 1-5 and M Oshana 'How Much Should we Value Autonomy' (2003) 20(2) *Social Philosophy and Policy Foundation* 99- 107.

²¹⁶ S McLean and J Mason *Legal and Ethical Aspects of Healthcare* p. 47.

MacLean's earlier arguments, it seems the information that the patient needs in order to allow a proper exercise of autonomy is what would enable him to consider the risks and effects of the available options (including not receiving treatment at all) rather than details of procedures that would have no importance to the decision whether to give consent. A doctor might therefore legitimately decide to withhold information that would not be helpful to the patient in making his decision, such as details of the kinds of instruments that will be used in surgery. This is not without difficulty, since individual doctors and patients may differ about the relevance of particular information. This emphasises the need for discussion with patients about what kind of information it is important to them to know.

However, it has been observed that there might be other situations when withholding information might be considered, for example, when doctors believe that the treatment or medical procedures would be beneficial and in the patients' best interests, and in such cases they may wish to withhold information if they believe that patients might not consent to the treatment if they were told about the risks.²¹⁷

Thus another justifiable case based on beneficence principle is when the disclosing of the information would cause serious harm to the patient; in such a case, it can be argued that the doctor can be permitted to withhold such information, as providing it would cause distress to the patient and may worsen his conditions.²¹⁸ Thus, it can be argued that the use of withholding information indicates that there might be a very small scope for such a conclusion to be drawn, that withholding information might be ethically justifiable. It is here that the distinction between beneficence and paternalism is at its most significant. The notion of beneficence focuses on the idea of informing the patient about the best options for the patient, while allowing/enabling them to make their own decisions, whereas, paternalism is an absolute disregarding of the patient's wishes and views, because paternalistic doctors are deciding on behalf of their patients.

This notion of withholding information seems to be considered by Islamic *Sharia* medical ethics and by both English and Saudi Arabian laws, though it has been narrowed and used with caution, as the thesis will discuss in Chapters two, three and four.

The consideration of whether it is ever ethically acceptable to withhold information leads to a further question; whether the patient is obliged to receive information in order for his

²¹⁷ R Epstein *et al* 'Withholding Information from Patients —When Less is More'(2010) 362(5) *N Engl J Med* 380-381 p. 380.

²¹⁸ J Mason and G Laurie *Mason and McCall Smith's Law and Medical Ethics* (9th ed OUP 2013) p. 118.

decision to be regarded as an autonomous one. It has been said there is no ‘right to not be informed’ since to recognise this kind of right is critically damaging to the notion of ethical agency.²¹⁹ Nevertheless, there has been some discussion of and support for a right not to know, for example in relation to genetic information. It has been suggested that people may have a desire to remain ignorant regarding significant genetic information about oneself: whether or not an individual has a gene for a distressing illness that may affect his children or family.²²⁰ Although there are some arguments that would support the right not to know regarding genetic information,²²¹ this is a matter about which there is considerable debate, and others take the view that even such information requires to be disclosed.²²² As this thesis is not focused on genetic information, this particular situation will not be discussed further but the issue has arisen in the context of consent to treatment.

Beauchamp and Childress have suggested that there can be situations where a patient may voluntarily waive the right to receive information him/herself but enable it to be given to another (a representative) or for information not to be provided at all.²²³ Nevertheless, Beauchamp and Childress seem to hold that such a right exists, although they have argued that an acceptance of the right to not receive information would be ‘dangerous’ because great number of patients ‘have an inordinate trust’ in their doctors and may make the patient very ‘vulnerable’ specifically when the interests of the doctor and patients are different and conflict.²²⁴ The issue of waiving will be discussed in Chapter two based on Islamic *Sharia* perspective.

However, in relation to the right not to know, it can be argued that the provision of sufficient information has become regarded as an essential element to exercise autonomy and to a decision being regarded as sufficiently autonomous. Thus, a decision that is made without sufficient information cannot be considered as autonomous and is not consequently deserving of respect. Firstly, as Rhodes expressed that ‘if autonomy determines my right to

²¹⁹D Ost ‘The Right Not to Know’ (1984) 9 *The Journal of Medicine and Philosophy* 301-312 p. 303.

²²⁰M Sheehan and J Martin ‘Can Broad Consent be Informed Consent?’ (2011) 4(3) *Public Health Ethics* 226-235 p. 229-230.

²²¹For example, G Laurie ‘Recognizing the Right Not to Know: Conceptual, Professional, and Legal Implications’ (2014) 42(1) *The Journal of Law, Medicine and Ethics* 53-63 and R Andorno ‘The Right not to Know: An Autonomy Based Approach’ (2004) 30 *J Med Ethics* 435-440

²²²For examples, T May and R Spellecy ‘Autonomy, Full Information, and Genetic Ignorance in Reproductive Medicine’ (2006) 89(4) *the Monist* 466-481 and G Helgesson ‘Autonomy, the Right Not to Know, and the Right to Know Personal Research Results: What Rights Are There, and Who Should Decide about Exceptions?’ (2014) 42(1) *the Journal of Law, Medicine and Ethics* 28-37.

²²³T Beauchamp and J Childress *Principles of Biomedical Ethics* p. 137.

²²⁴Ibid.

knowledge, it cannot also justify my refusing to be informed.²²⁵ Secondly, the principle of respect for autonomy involves an obligation to respect a competent adult patient's autonomous decision because if '...respecting decisions is about enabling a person to develop his or her vision of the good life, then those decisions will help to achieve the goals the person is aiming for only if the person has the information needed to reach that decision.'²²⁶ Thus, a patient decision's to remain ignorant about significant facts makes his/her decision not an autonomous one, so based on this argument there is no right not to know information.²²⁷ On the other hand, I would argue that, if the patient refuses to be informed, it would be better to say that doctors can and should seek to persuade the patient to accept information in order to arrive at a choice.²²⁸ As I have argued above, persuasion to assist the patient to make his/her decision would not breach the respect for his/her autonomy or invalidate his/her consent, although doctors should not force information on a clearly unwilling patient and they can treat on this basis. In such cases, decisions made should probably be treated with caution, but it should not be open to a patient to say that his/her decision was not sufficiently autonomous if he/she refused to be given information.

Based on what has been discussed above about autonomy in the medical context, it seems clear that autonomy has played a vital role in setting the standard of information disclosure and what should be disclosed, as well as how that information should be delivered. I would conclude that there is a clear connection between the development of the standard of information disclosure and respect for patient autonomy. This is because, for a decision to be considered autonomous, information should be provided that is clear and that the patient can understand. This kind of protection and focus on the amount of information shows that autonomy is a crucial factor in medicine, as it has underpinned the protection of patients and enabled them to make free decisions.

2.9. Conclusion

In this section, I have examined the concept of the principle of respect for autonomy and its values and limitations. The principle of respect for autonomy has been examined through the heritages of Kant and Mill and it has been explained that although in some ways their approaches are very different, both have expressed support for the fundamental importance

²²⁵ R Rhodes 'Genetic Links, Family Ties, and Social Bonds: Rights and Responsibilities in the Face of Genetic Knowledge' (1998) 23(1) *Journal of Medicine and Philosophy* 10–30 p. 18.

²²⁶ C Foster and J Herring "'Please Don't Tell me": The Right not to Know.' (2012) 21 *Cambridge Quarterly of Healthcare Ethics* 20–29 p. 21.

²²⁷ J Harris and K Keywood 'Ignorance, Information and Autonomy.' (2001) 22(5) *Theoretical Medicine and Ethics* 415–436 p. 422.

²²⁸ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 180-182.

of autonomy. It has also been shown that, while Western medical ethics and practice were founded on the principle of beneficence, which led to paternalistic approaches to providing care, this has been retreated from and respect for patient autonomy has become of fundamental importance. It now seems to underline most doctor-patient interactions including consent to medical treatment and information disclosure.

Although there are limitations to respect for autonomy such as the harm principle, this does not undermine autonomy as the most dominant ethical principle in current Western medical ethics. For a decision to be regarded as autonomous there are some conditions that should be met. Among those elements are competence and voluntariness. As the focus of this thesis is the competent adult, these concepts will not be treated in further detail. The final element of considering the patients' decisions as autonomous ones is that they should be based on adequate information. From what has been discussed, I would argue that the principle of respect for autonomy places an ethical duty on doctors to provide patients with medical information regarding their health conditions and treatments.

A further vital issue is regarding what the appropriate standard of information disclosure might be. I have presented the approach of full disclosure of information to patients which seems as if it might be an ethical ideal but as above discussed it is unlikely to be achievable or necessarily desirable in achieving the object of allowing patients to make decisions effectively for themselves. Instead, there have been different alternative standards considered. O'Neil's suggested proposal relies on the notion of trust. Relying on trust was argued to be problematic as it may retain the idea of paternalism. Further difficulties in the concept of trust will be explored in more detail in the next section, but for these reasons this approach was rejected. Instead, this thesis proposes to adopt as an ethical ideal a standard of information disclosure that places emphasis on the needs of the patient for relevant information to be able to arrive at a decision. This information would include diagnosis, prognosis, proposed treatments and their risks and benefits as well as the available alternative options of treatment. Further, it should also be acknowledged that the patient needs to have understandable and clear information so information should be provided to support as far as possible the understanding of the patient.

It should also be said that the standard of information disclosure should not be set too high as that would be difficult to meet for both doctors in terms of requiring them to provide information and for patients. Furthermore, although there have been ongoing arguments about the nature and degree of information that should be disclosed to patients, it seems that

respect for autonomy would insist that the patient should be sufficiently informed to consider his decision as an autonomous one.

Having set out what the ethical ideal is for the standard of information disclosure in order to respect patient autonomy, Chapter three will consider to what extent this standard has been met by UK law.

Before turning to that, however, there are two remaining issues to consider. The next section will go on to examine an alternative principle as a means of establishing the duty to provide information to patients. It will explore the notion of trust and how it has been considered from a Western ethical point of view, and discuss its relationship to the principle of respect for competent adult patients' autonomy. Earlier in this Chapter, it was argued that the notion of trust should not be emphasised in terms of patients' consent and information disclosure as that would recall the era of paternalism, which has fallen into disfavour. However, it is still important to consider it here since the issue of trust will be revisited in Chapter two. There it will be argued that it is still significant as one of the fundamental ethical principles of the provision of care under Islamic *Sharia* and Saudi Arabian medical ethics, and that this has influenced the direction of legal regulation in Saudi Arabia.

3. The notion of trust

3.1. An overview of trust

In general, trust can be described as a 'firm belief in the reliability, truth or ability of someone or something'.²²⁹ The term trust is frequently used interchangeably with other terms, for example, confidence and belief in another.²³⁰ It has therefore been observed that 'trust is a dynamic aspect of interpersonal relationships that involves the complex and interwoven perspectives of the truster, the one trusted, and the object of one's trust'.²³¹ It can be argued that without trust, a person would not be able to co-operate with another person or be involved in activities with others.²³² Trust in others is essential to people and without it they could not live and thrive.²³³

²²⁹ Oxford online dictionaries at <http://www.oxforddictionaries.com/definition/english/trust> (accessed 05/01/2015).

²³⁰ K Lord *et al* 'Measuring Trust in Healthcare Professionals a Study of Ethnically Diverse UK Cancer Patients' (2012) 24 *Clinical Oncology* 13-21 p. 13.

²³¹ I Melo-Martin and A Ho 'Beyond Informed Consent: The Therapeutic Misconception and Trust' (2008) 34 *Journal of Med Ethics* 202-205 p. 202.

²³² R Fox 'Training for Uncertainty' in R Merton, G Reader and P Kendall (eds.), *The Student Physician* (HUP 1957) p. 207-241.

²³³ I Melo-Martin and A Ho 'Beyond Informed Consent: The Therapeutic Misconception and Trust' p. 202.

O'Neill has linked the idea of trust to the concept of relationships and obligations as trust is one of the main elements in any personal relationship.²³⁴ Jones has also suggested that trust is vital in relationships,²³⁵ and other commentators have noted that '...trust encourages us to see and respect each other as moral agents'.²³⁶ Therefore, the question here is whether trust as a concept can be considered as the ethical basis for information disclosure and consent to treatment in the case of competent, adult patients.

3.2. Trust, patient's consent and information disclosure

It has been argued that the doctor-patient relationship can be considered as a caring relationship, because doctors take care and provide treatment to patients to benefit the patient's health.²³⁷ Thus, to achieve the goal of benefiting the patient's health through the doctor-patient relationship, that relationship demands trust, 'because of the significant benefits that it [trust] promotes and the harms that it [trust] helps to prevent.'²³⁸ A relationship that is built on trust would support the idea of shared decision-making, to recognise the doctors' duty to act in a trustworthy sense. Rhodes has held that 'all reasonably farsighted physicians must recognize that in order to practice medicine, they must *seek trust and deserve it*'.²³⁹ (Her emphasis). Rhodes has justified that '[b]ecause this rule follows from a reasonable consideration of the basic requirements for medical practice, it is the fundamental *prima facie* moral imperative for doctors, the ethical rule that must always be taken into account in their practice.'²⁴⁰ (Her emphasis). This view in fact seems to hold that the notion of trust should be the main ethical principle in the doctor-patient relationship and marginalises other ethical principles such as respect for autonomy. This follows from Rhodes's assertion that '...all doctors must accept [to] *seek trust and deserve it* as their moral law, as their creed.'²⁴¹ (Her emphasis). Thus, doctors should act in a way that promote trust and make 'themselves trustworthy practitioners.'²⁴²

²³⁴ O'Neill *Autonomy and Trust in Bioethics* p. 25.

²³⁵ K Jones 'Trust as an Affective Attitude' (1996) 107 *Ethics* 4–25 p. 4.

²³⁶ I Melo-Martin and A Ho 'Beyond Informed Consent: The Therapeutic Misconception and Trust' p. 204.

²³⁷ For examples, L Gilson 'Trust and the Development of Health Care as a Social Institution' (2003) 56 *Social Science & Medicine* 1453–1468, H Alder 'The Sociophysiology of Caring in the Doctor-patient Relationship' (2002) 17(11) *J Gen Intern Med* 883–890 and D Lynn-McHale 'Trust Between Family and Health Care Provider' (2000) 6(3) *Journal of Family Nursing* 210-230.

²³⁸ B McCullough 'Trust, Moral Responsibility, the Self, and Well-ordered Societies: The Importance of Basic Philosophical Concepts for Clinical Ethics' (2002) 27(1) *Journal of Medicine and Philosophy* 3-9 p. 5.

²³⁹ R Rhodes 'Understanding the Trusted Doctor and Constructing a Theory of Bioethics' (2001) 22 *Theoretical Medicine* 493-504 p. 495.

²⁴⁰ *Ibid* 495-496.

²⁴¹ *Ibid* p. 496.

²⁴² *Ibid*.

Bearing in mind Rhodes's argument above, it can be argued that the notion of trust seems to be not clear enough to be considered as adequate to protect patients in the healthcare context. Arguably, even O'Neill with her major work on trust did not give a straightforward answer to what the concept of patients' trust in their doctors is founded on; she noted that '[s]ometimes we may know that good will is lacking, and yet we trust'.²⁴³ As an example, she stated that '[a] patient may know a doctor finds him particularly irritating and bears him little good will, and yet trust the doctor to exercise proper professional judgement'.²⁴⁴ This may indicate that even where the personal relationship is problematic, patients may still trust doctors to conduct themselves professionally.²⁴⁵ On the other hand, patients might not trust their doctors, but they might still rely on them because they do not have other options or choices.²⁴⁶ Therefore, trust can be said to be marginalised if the patient puts his care into doctors' hands where he does not have a choice.²⁴⁷ Therefore, it has been suggested that for the notion of trust to work maximally it requires confidence in both the ability and good will of the trusted.²⁴⁸

It has been claimed that trust is one of the central elements in the relationship between patients and their physicians and indeed McCullough has suggested that 'trust...should be understood as a foundation for the physician-patient relationship'.²⁴⁹ Therefore, it has been argued that the idea of trust is very important in the concept of ethical medical practice.²⁵⁰ Based on that it has been suggested that patients' giving consent to treatment was seen as being built on trust,²⁵¹ and that this concept would help to make co-operation between patients and their doctors easier. Thus, trust can play an important role in providing a benefit to the patient in terms of health outcomes, since the patient may be involved in making his/her own decision, by communicating with doctors so that would be a part of the success of the treatment course.²⁵²

²⁴³ O'Neill *Autonomy and Trust in Bioethics* p.14.

²⁴⁴ *Ibid.*

²⁴⁵ D Sellman 'Trusting Patients, Trusting Nurses' (2007) 8 *Nursing Philosophy* 28–36 p. 29.

²⁴⁶ *Ibid.*

²⁴⁷ A Baier 'Trust and Antitrust' (1986) 96(2) *Ethics* 231-260 p. 234.

²⁴⁸ K Jones 'Trust as an Affective Attitude' p. 4.

²⁴⁹ B McCullough 'Trust, Moral Responsibility, the Self, and Well-ordered Societies: The Importance of Basic Philosophical Concepts for Clinical Ethics' p. 5.

²⁵⁰ R Rhodes 'Understanding the Trusted Doctor and Constructing a Theory of Bioethics' p. 496. See also S Joffe, *et al.* 'What Do Patients Value in their Hospital Care? An Empirical Perspective on Autonomy Centred Bioethics' (2003) 29 *J Med Ethics* 103–108 p. 104 and A Jacobs 'Rebuilding an Enduring Trust in Medicine: A Global Mandate: Presidential Address American Heart Association Scientific Sessions 2004' (2005) 111 *Circulation* 3494-3498.

²⁵¹ A Tauber 'Sick Autonomy' (2003) 46(4) *Perspectives in Biology and Medicine* 484-495 p. 491.

²⁵² R Harper *Medical Treatment and the Law, the Protection of Adults and Minors in the Family Division*. (Jordans Ltd 1999) p. 3 and H Teff 'Medical Models and Legal Categories: An English Perspective' (1993) 9 *Journal of Contemporary Health Law and Policy* 211-232 p. 221-224.

However, for the arguments that see trust as an important factor for obtaining the patient consent,²⁵³ it is equally vital for the same arguments to hold that patients would trust their doctors to provide them with the information that they need and wish to know about their health conditions to make a decision regarding their cases.²⁵⁴ Trust can be related to providing a patient with information if the doctor is regarded as having a duty to offer the patient information that is ‘accessible and reliable.’²⁵⁵ There is some evidence that demonstrates that a large number of patients continue to trust doctors and medical staff and allow them to be involved in making their decision, rather than seeing this as a matter entirely for a patient to make alone.²⁵⁶ Some studies have found that patients’ involvement in their decision-making is different based on their social and cultural background.²⁵⁷ Certain patients may rely on their doctors and not wish to be involved in the decision-making process, so doctors may take a more major role in deciding upon treatment.²⁵⁸

However, to rely entirely on the notion of trust can be seen as undermining the competent adult patient’s autonomy and ability to make their decision freely because ‘[t]o trust is thus to let go, to be vulnerable and deferent to another’s competence and responsibility.’²⁵⁹ It might imply that a patient is to be regarded as a ‘vulnerable’ person who leaves others to act on his or her behalf. In other words, once a relationship of trust is entered into, patients need not be actively involved in making decisions, since they can trust their doctor to do what is best for them. In this way, reliance on a principle of trust is clearly related to the notion of paternalism, which as has been discussed, may come into conflict with a principle of respect for autonomy that sees individuals as being best placed to make decisions for themselves.

²⁵³ A Tauber ‘Sick Autonomy’ p. 491.

²⁵⁴ A Kao *et al* ‘Patients’ Trust in their Physicians Effects of Choice, Continuity and Payment Method’ (1998) 13 *J Gen Intern Med* 681-686 p. 681 and R Sullivan, L Menapace and R White ‘Truth-Telling and Patient Diagnoses’ (2001) 27 *Journal of Medical Ethics* 192-197 p. 192.

²⁵⁵ D Mechanic ‘In my Chosen Doctor I Trust and That Trust Transfers from Doctors to Organisations’ (2004) 329 *BMJ* 1418-1419 p. 1419.

²⁵⁶ For example, O Ommen *et al* ‘Trust, Social Support and Patient Type—Associations between Patients Perceived Trust, Supportive Communication and Patients Preferences in Regard to Paternalism, Clarification and Participation of Severely Injured Patients’ (2008) 73 *Patient Education and Counseling* 196–204, N Kraetschmer *et al* ‘How does Trust Affect Patient Preferences for Participation in Decision-Making?’ (2004) 7 *Health Expectations* 317–326 and C Tarrant, T Stokes and R Bake ‘Factors Associated with Patients’ Trust in their General Practitioner: A Cross-Sectional Survey’ (2003) 53 *British Journal of General Practice* 798-800.

²⁵⁷ For examples, T Guffey and P Yang ‘Trust in Doctors: Are African Americans less Likely to Trust their Doctors than White Americans?’ (2012) October-December *SAGE J* 1 –8, D Musa *et al* ‘Trust in the Health Care System and the Use of Preventive Health Services by Older Black and White Adults’ (2009) 99(7) *American Journal of Public Health* 1293-1299 and C Charles ‘Cultural Influences on the Physician–Patient Encounter: The Case of Shared Treatment Decision-Making’ (2006) 63 *Patient Education and Counseling* 262–267.

²⁵⁸ W Levinson *et al* ‘Not All Patients Want to Participate in Decision Making A National Study of Public Preferences’ (2005) 20(6) *Journal of General Internal Medicine* 531-535 p. 534.

²⁵⁹ O Quick ‘Outing Medical Errors: Questions of the Trust and Responsibility’ (2006) 14 *Medical Law Review* 22–43 p. 35.

It has been argued that the idea of competent adult patients making their own decisions and not automatically conceding the power to others, even doctors, to make decisions for them has become vital to medical ethics due to the rise in prominence of the principle of respect for autonomy.²⁶⁰ From what has already been said about the retreat from paternalism it appears now that this respect for autonomy in the practice of medicine is widely regarded as being more significant than the notion of trust. Despite this, Rowe and Calnan have argued that the idea of ‘inter-dependence’ between patients and their doctors means that the need for the notion of trust in medical encounters has not been dismissed, but ‘...trust is now more conditional and negotiated and depends on the communication, provision of information, and the use of ‘evidence’ to support decisions’.²⁶¹ This claim shows the weakness of considering the notion of trust rather than autonomy as the main principle of the patient-doctor relationship that should determine the duties of a doctor to disclose information. Indeed, as suggested here, establishing and maintaining trust may be conditional upon the provision of information, rather than providing the reason for doing so. Other factors have also been put forward as relevant to trust. For example, it has been argued that factors such as the level of care and comfort received, how doctors behave, and whether there are good interactions and communication skills are all important.²⁶² These factors can be seen to be significant and affect patients’ satisfaction, which may in a circular way also have an impact on patients’ trust in their doctors.²⁶³ This line of argument would suggest that it should be recognised that trust requires consideration and support of a range of patients’ rights.²⁶⁴ These would include the idea that doctors should encourage patients to be involved in the decision-making.²⁶⁵ If this is accepted, then this must surely require doctors to provide information and find out about patients’ needs in order to involve them in a meaningful way. In fact, such an argument would show that the focus is on doctors’ behaviour and how they deal with patients, which may suggest that trust is always focused on how the professional should behave and deal with patients. Such an emphasis would suggest that to inform the patient or to obtain his or her consent is left to the way the doctor behaves rather than the respect for patient autonomy, which retains the idea of paternalism.

²⁶⁰ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 44.

²⁶¹ R Rowe and M Calnan ‘Trust Relations in Health Care—the New Agenda’ (2006) 16(1) *Eur J Public Health* 4-6 p. 5.

²⁶² S Pearson and I Raeke ‘Patients’ Trust in Physicians: Many Theories, few Measure and Little Data’ (2000) 15 *J Gen Intern Med* 509-513 p. 509.

²⁶³ D Thom ‘Physician Behaviors that Predict Patient Trust’ (2001) 50(4) *the Journal of Family Practice* 323-328.

²⁶⁴ T Dovies ‘Consent to Treatment Trust Matters as Much as Information.’ (1997) 21 *Psychiatric Bulletin* 200-201 p. 201.

²⁶⁵ D Mechanic and S Meyer ‘Concepts of Trust among Patients with Serious Illness.’ (2000) 51(5) *Social Science and Medicine* 657–668 p. 667.

Plainly, another weakness of the notion of trust can be understood from the concern about the potential for a type of trust that may be deemed ‘blind trust’, which may, for example, discourage patients from asking questions that it might be thought necessary and important to ask. For example, Mechanic and Meyer have cautioned that: ‘In emphasizing the importance of trust, we do not suggest that patients should trust blindly. Patients and professionals both need better preparation for establishing effective therapeutic alliances’.²⁶⁶ It can be said that, even with the avoidance of the idea of ‘blind trust’, it seems that relying on trust as a basis for approaching information disclosure would be problematic as some patients would be likely to feel that their autonomy and views, goals, and decisions were not being sufficiently respected or appreciated if they are not in control of decisions about their healthcare.²⁶⁷ For patients to not feel any kind of acknowledgement that their own views and wishes deserve respect from the doctors who would act on their behalf may also lead them to lose confidence and trust in medical care.²⁶⁸ In turn, this might deter them from seeking medical advice and treatment because they feel that they are not being respected for themselves or for their freedom to make decisions.²⁶⁹ Reliance on trust as a concept might therefore ultimately undermine the establishment of a relationship of trust in practice, and lead to worse health outcomes for patients.

Davies has sought to avoid the principles of respect for autonomy and trust as being seen to be in conflict. Instead he has emphasised that both trust and giving information to patients should work side by side and reciprocally and that valid consent should be based on both information and trust, stating that ‘[c]learly, information is only half the story’.²⁷⁰ On this view, that fact that information has been provided is less significant to being able to rely on the patient’s consent than it would be if respect for autonomy alone were the guiding principle: there must also be trust. Davies then has justified his view by saying that ‘[p]atients are unlikely to have confidence in the information they are given unless they have confidence in the system providing it, and that confidence is a function of the patient’s trust in the doctor’.²⁷¹ In fact, Davies claims that the notion of trust he has offered is not in conflict with patients’ ‘autonomy’ or ‘rights’ ‘to be provided with or to decline information’.²⁷²

²⁶⁶ Ibid.

²⁶⁷ L Furst *Between Doctors and Patients the Changing Balance of Power* p. 1 and 18.

²⁶⁸ R Say, M Murtagh and R Thomson ‘Patients’ Preference for Involvement in Medical Decision Making: A Narrative Review’ (2006) 60 *Patient Education and Counseling* 102–114 p. 113–114.

²⁶⁹ J Coy ‘Autonomy-based Informed Consent: Ethical Implications for Non-Compliance’ p. 829.

²⁷⁰ T Davies ‘Consent to Treatment: Trust Matters as Much as Information’ (1997) 21 *Psychiatric Bulletin* 200–201 p. 201.

²⁷¹ Ibid.

²⁷² Ibid.

However, I would argue that Davies's view would retain the idea of paternalism in the medical context as doctors could find justification and support to provide the information that they want to give, instead of what patients need and require, as he stated that '...developing trust entails full cognisance of the patient's rights and of the doctor's responsibilities, including the recognition that doctors have other important duties to their patients than solely respecting their autonomy'.²⁷³

In the same line with Davies's view, Brewin who is a strong supporter of a trust based ethic of healthcare argued that the strongest arguments against it being given priority in the doctor-patient relationship are from those who he described as 'anti-paternalist' who would prefer others to be given facts to make their own choices, aiming to respect their autonomy.²⁷⁴ He himself seemed unhappy for others to be given facts about their health conditions and limited their involvement in decision-making to being advised, which seems to be a firmly paternalistic view. Brewin suggested that '[w]hat we need is better communication; more explanation for those who need it, less for those who don't; [*sic*] and greater empathy and understanding of the patient's real needs, fears, and aspirations'.²⁷⁵ Brewin did not stop his attack on 'anti-paternalists' and ultimately autonomy, as he then argued that '[w]hat we don't [*sic*] need is unhelpful rhetoric; a wholesale attack on trust; excessive emphasis on 'fully informed consent' and 'autonomy'; and a serious distortion of priorities with a consequent fall in standards of care'.²⁷⁶ Brewin then justified his argument for two reasons:

'Firstly, because noble principles often give contradictory advice. Every patient has a right to full information. He also has a right to be treated with compassion, common sense, and respect for his dignity-a respect that is not usually enhanced by asking him, 'Do you want us to be frank about all the risks or not?' Secondly, because we are all the prisoners of time, the more time we spend trying to explain things, the less there is for other aspects of patient care.'²⁷⁷

With all due respect to Rhodes's and Brewin's views, these views would clearly retrieve the notion of paternalism as they may be taken to suggest that the patient should just passively attend hospital and leave the decision-making for doctors only. This idea of paternalism has now no place in modern medical ethics. As the thesis has argued, acting paternalistically

²⁷³ Ibid.

²⁷⁴ T Brewin 'Truth, Trust, and Paternalism' (1985) 31 *the Lancet* 490-492 p. 491.

²⁷⁵ Ibid.

²⁷⁶ Ibid.

²⁷⁷ Ibid.

violates and breaches the patient's autonomy to make a free choice and decision. In fact, even the law,²⁷⁸ as will be discussed in Chapter three, has rejected the idea of paternalism.

Arguably trust should not be absolutely dismissed, but to regard it as the fundamental ethical principle on which to base an appropriate approach to information disclosure would be difficult to apply and defend. For example, although Rhodes holds that trust is vital in medical ethics, she seems to attempt to adjust her view to accommodate it with the principle of respect for autonomy. She argued that:

‘To be trusted, the doctor will also have to pay serious attention to the patient’s view of what is good. People like to have their own way, and when decisions are intimately concerned with the patients’ own body and life, differences between alternatives can be tremendously important to them.’²⁷⁹

Rhodes has admitted that ‘[s]ometimes a doctor’s view of what is best can be at odds with a patient’s view. In some circumstances a patient will actually consider the doctor’s choice to be no good at all.’²⁸⁰ She then argued that, as the doctor-patient relationship builds on trusting doctors, that would not allow doctors to impose their view against the patients’ own views.²⁸¹ However, when Rhodes has concluded her discussion she seems to hold the opposite view, as she has said: ‘In sum, in order for doctors to be trusted to a degree that allows them to act for their patients’ good, they are committed to making themselves professionally competent, caring, and respectful of patient values.’²⁸²

I would argue that Rhodes seems, on one the hand, to argue that trust is a vital ethical element that should underpin medical ethics and allow doctors to act in their patients’ interests, which would suggest that providing information to patients to enable them to make their own decisions is less of a priority. On the other hand, she seems to contradict her argument, as doctors should not impose their own view in order to respect the patient’s values and desires. This shows that she seems to support the principle of respect for autonomy but at the same time still holding the support of trust.

It seems from the arguments above that, nonetheless, the notion of trust may still have a place in medical ethics, but more emphases on it would not be defensible. This is because the notion of trust would undermine the patient’s view, values and wishes, as trust seems to suggest that doctors can decide what information should be given and even may consent on

²⁷⁸For example, *Chester v Afshar* [2004] UKHL 41.

²⁷⁹R Rhodes ‘Understanding the Trusted Doctor and Constructing a Theory of Bioethics’ p. 496.

²⁸⁰*Ibid.* p. 497.

²⁸¹*Ibid.*

²⁸²*Ibid.* p. 498.

behalf of the patients. This would show difficulties in how to set a standard of information disclosure that just relies on trust, which prefers to empower doctors and marginalise patients' views and wishes.²⁸³ I have argued above that the principle of respect for patient autonomy would give more power to the patient and balance the doctor-patient relationship. Thus the notion of respect for patient autonomy is defensible and would give more protection to patients and their views and wishes would be respected and considered. Thus, respect for autonomy would require doctors to respect patients' values and views and provide them with sufficient information to make their free decision. Thus, as the thesis will argue in Chapter three, it is the notion of the respect for patient autonomy rather than trust that convinces the law to change to consider patients' views and provide them with information.

3.3. Conclusion

To conclude this discussion about the notion of trust, following the discussion of alternative approaches to trust, the question remains whether the concept of trust can be used as the overarching principle for determining the rights and duties of patients and doctors in respect of information disclosure and consent, rather than seeing autonomy as the pre-eminent principle that should be applied. With all due respect to some who have argued that the notion of trust is a vital concept in the medical ethics context and plays an important role in both patient consent and information disclosure, my conclusion is that it cannot fulfil such a central role.²⁸⁴

I would suggest that a preference for trust over the principle of respect for autonomy is not appropriate, since it would inevitably reintroduce the idea of paternalism. Patients' views and decisions would not be regarded as having as great a significance as they do under the principle of autonomy, and this would reverse the trend that I set out earlier.

I would argue that trust as the foundation of information disclosure would not be the right and defensible approach since it has been observed that:

‘Trust is necessary in asymmetrical relationships with all their imbalances of knowledge and power. It is, thus, largely reliant on ignorance and uncertainty, and may be protected by secrecy. The stranglehold that doctors traditionally enjoyed over medical knowledge and information about the quality of healthcare has been significant in sustaining trust.’²⁸⁵

²⁸³ B McKinstry ‘Paternalism and Doctor-Patient Relationship in General Practice.’(1992) 42 *British Journal of General Practice* 340-342 p. 342.

²⁸⁴ For examples, O’Neill *Autonomy and Trust in Bioethics*, M Sagoff ‘Trust Versus Paternalism’ (2013) 13(6) *The American Journal of Bioethics* 20-21, M Hall ‘Law, Medicine, and Trust’, A Tauber ‘Sick Autonomy’ and A Kao *et al* ‘Patients’ Trust in their Physicians Effects of Choice, Continuity and Payment Method’.

²⁸⁵ O Quick ‘Outing Medical Errors: Questions of the Trust and Responsibility’ p.35-36.

Hence, to ground providing information to patients in the notion of trust maintains the power imbalance whereas my position would be that making respect for autonomy the guiding principle seeks to redress that. Providing information to patients, as a consequence of their right to respect for autonomy, gives them knowledge to make their own decisions rather than having treatment decisions based on a matter of having to trust the doctor to give them information or make the 'right' decision for them. In fact, a reliance on trust in the form above discussed would generate a barrier between doctor and their patients in decision making, because doctors could ignore a patient's views if they believed that this was in the patient's best interests and that they were being trusted only to produce a good medical outcome.

Thus, what patients need is to be respected and provided with information that meets their own needs, wishes and values to allow them to make an autonomous decision not to just remain passive and rely upon the judgement of their doctors because they are required to trust them.²⁸⁶ That can only be achieved by respecting the patient's autonomy and his autonomous decisions. The issue of trust is a concept that has remained central in Saudi Arabia, as will be examined in Chapter two.

After having discussed the Western medical ethics perspective on respect for autonomy and the notion of trust and how have they been considered in the medical context, in the following it is worth considering English law sources and their relation to ethics, to show how English law has considered ethics. This will be further explored in Chapter three.

4. The sources of English law and its relation to ethics

As the thesis is examining the matter of the information disclosure standard for competent adult patients' from both ethical and legal perspectives, it is important to understand the relationship between them. The legal system of Saudi Arabia is based very clearly on religious and ethical principles derived from the Islamic faith and this continues to be central to its development. It is therefore useful to provide a brief overview of the sources and development of English law as a means of comparison and to give some consideration to what has been said about ethics, in particular medical ethics, in relation to English law.

²⁸⁶H Engelhardt *The Foundations of Bioethics* (2nd ed OUP 1996) p. 355-357.

4.1. English law: sources of law

The development of English law has a long history.²⁸⁷ The English legal system is a common law system which is ‘case-centred and hence judge-centred, allowing scope for a discretionary, *ad hoc*, pragmatic approach to the particular problems that appear before the courts.’²⁸⁸ (Original emphasis).

Historically, the term common law has its association with the notion that it is the English people’s common law, which has existed since the Norman Conquest of England when a unified legal system was necessary to demonstrate the affirmation of the power of the sovereign over the state.²⁸⁹

Common law is still one of the most fundamental sources of the legal principles and rules that are applied through the doctrine of precedent.²⁹⁰ In fact, the early main notion of developing the common law was that ‘a right only existed if there was a procedure for enforcing it ..., and for this reason substantive law became inextricably bound up with procedure.’²⁹¹ Therefore, the nature of the matter came to determine which court is the right one for considering that matter. However, in terms of the common law system of hierarchy, decisions made in the higher courts are binding on the lower courts, as well as generally dealing with more complex matters.

Besides the common law as the traditional source of English law, the other major source of law is legislation.

4.1.1. Legislation

The United Kingdom (UK) Parliament at Westminster is the main legislative body for England.²⁹² Most legislation is proposed by the elected Government though it is possible for private members bills and in rare cases proposals from those outside Parliament to become Bills. The legislation must be debated and approved by both Houses of Parliament – the elected House of Commons and the unelected House of Lords.²⁹³ Parliament, since its

²⁸⁷ J Baker *An Introduction to English Legal History* (3rd ed Butterworths 1990) p. 1.

²⁸⁸ G Slapper and D Kelly *The English Legal System* p. 3.

²⁸⁹ R Caenegem *The Birth of the English Common Law* (2nd ed CUP 1988) p. 3-5.

²⁹⁰ M Zander *The Law-Making Process* (6th ed CUP 2004) p. 265-266.

²⁹¹ R Ward and A Wragg *Walker and Walker’s English Legal System* (9th ed OUP 2005) p. 5.

²⁹² The UK government has devolved some power to other three parliaments in the country; the Scottish Parliament, the National Assembly of Wales and the Northern Ireland Assembly. Which each one has devolved power to establish a law that has a regional effect and enforcement.

²⁹³ M Zander *The Law-Making Process* p. 53-70 and ‘Making Laws’ the UK Parliament at <http://www.parliament.uk/about/how/laws/> (accessed 11/06/2015).

establishment²⁹⁴ has become one of the major sources of English law through the enactment of statutes and associated legislation, and legislation has increasingly become the dominant form for creation of laws and legal reform. The courts have acknowledged that by preferring that the development of any new legal principle should be considered by Parliament, rather than through the development of common law.²⁹⁵ Parliament has the power to establish laws; to reform, amend or abolish an existing common law principle and existing legislation and it can also adopt international laws or treaties.²⁹⁶

Apart from these major sources of English law, a brief mention may be made of some others although this is not intended to provide an exhaustive list. The concept of equity arose to correct perceived inflexibility and deficiencies in common law. The existence of equity generated two different legal systems and courts for common law and equity.²⁹⁷ However, these were merged by the Judicature Acts of 1873 and 1875. Custom has also played a part in the development of English law. Although it is rarely directly used to determine legal issues now, many rules of customary law have been adopted and developed by judges through the common law, others have become part of statute law.²⁹⁸

Canon law is also particularly worth mentioning since, as will be seen later, law in Saudi Arabia is profoundly influenced by religion. Canon law is the law that has been based on the teachings and authority of the Catholic Church and which was used to deal with both offences against the church and other matters such as inheritance of property.²⁹⁹ However, it has been said that ‘mediaeval canon law is part of English law *only* to the extent that it is *incorporated into English law*. It may be incorporated in one of two ways: (1) expressly, by being codified as statute law or (2) implicitly, by the sanction of ‘immemorial usage and custom’ law.’³⁰⁰ (Original emphasis).

²⁹⁴ For further information about the history of the Parliament, C Jones *A Short History of Parliament: England, Great Britain, the United Kingdom* (1st ed Boydell Press 2009).

²⁹⁵ R Ward and A Wragg *Walker and Walker’s English Legal System* p. 5.

²⁹⁶ G Slapper and D Kelly *The English Legal System* p. 67-77 and R Ward and A Wragg *Walker and Walker’s English Legal System* p. 5.

²⁹⁷ R Ward and A Wragg *Walker and Walker’s English Legal System* p. 6.

²⁹⁸ D Keenan *Smith and Keenan’s English law* (13th ed Longman 2001) p. 14-15.

²⁹⁹ *Ibid.* p. 15.

³⁰⁰ P Jones ‘English Ecclesiastical Law is NOT Canon Law’ at <https://ecclesiasticallaw.wordpress.com/2012/05/19/english-ecclesiastical-law-is-not-canon-law/> (accessed 10/06/2015).

Despite not forming part of it, arguably canon law influenced English law in many ways, such as the use of punishment for crimes and the nature of Christian marriage and family affairs.³⁰¹ Other influence of canon law can be seen in term of the nature of equity law, because initially at least most of the Chancellors of the equity courts were clerics who applied religious moral and principles to the cases.³⁰² It has been suggested that Christian religious perspectives have continued to have some influence on English law for example, in *Donoghue v Stevenson*³⁰³ as Lord Atkin established the ‘neighbour principle’. It has been said that Lord Atkin’s motivation to set the principle was driven by his Christian faith, which was influential in his life.³⁰⁴ Such conclusions are hard to verify as they are based on observations about an individual’s personal convictions and there is no suggestion that Christian traditions should be treated as legally binding principles in themselves.³⁰⁵ However, it may at least suggest that the influence of religion may still play a role in legal development.³⁰⁶

Of much greater modern importance is the role of the European Union (EU). Since 1973, European Community (EC) law has become part of the UK legal system.³⁰⁷ EC organisations were transformed into the EU by a series of changes ending with the Treaty of Lisbon in 2009. Any English law in relation to the EU should be considered within the framework of EU law; in other words, the EU law can take precedence over the UK law.³⁰⁸ Further as the UK is a member of the Council of Europe, and following the incorporation of the European Convention on Human Rights (ECHR) into UK law by means of the Human Rights Act 1998, both legislation and court decisions should be compatible with the terms of the Convention.³⁰⁹

As will be explained in Chapter three, it has not generally been necessary to rely on the ECHR in order for a patient to have the legal right to make a decision for himself to consent to or refuse medical treatment, since this has been established under domestic law. There are some examples where patients have sought to allege that UK law that affects consent to

³⁰¹R Ward and A Wrang *Walker and Walker’s English Legal System* p. 9.

³⁰² *Ibid.*

³⁰³ *Donoghue v Stevenson* [1932] A.C. 562.

³⁰⁴ M Lunney and K Oliphant *Tort Law Text and Masteries* (3rd ed OUP 2008) p. 116.

³⁰⁵ For example, P Jones ‘The End of Canon Law in England’ at <https://ecclesiasticallaw.wordpress.com/2013/05/04/the-end-of-canon-law-in-england/> (accessed 10/06/2015).

³⁰⁶ For example, N Doe ‘The Principles of Canon Law’ (1999) 5(25) *Ecclesiastical Law Journal* 221-240.

³⁰⁷ M Zander *The Law-Making Process* p. 423.

³⁰⁸ R Ward and A Wrang *Walker and Walker’s English Legal System* p. 6-7.

³⁰⁹ E Wilson *et al. English Legal System* (1st ed OUP 2014) p. 216.

treatment is in breach of the ECHR, but these have usually concerned controversial types of treatment such as assisted suicide or voluntary euthanasia³¹⁰ or assisted reproduction.³¹¹ The ECHR will therefore not be discussed in detail in this thesis, but a brief mention of some of its Articles will be made in so far as it supports the contention that respect for patient autonomy can be found in this Convention and reference to its influence on UK law in more recent decisions such as *Montgomery v Lanarkshire Health Board*.³¹²

Article 2(1) states that: ‘Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally...’.³¹³ This article presents as a primary principle the right to life, and the requirement of the State to preserve and protect it. On the other hand the Article has also been cited to justify the idea of the patient’s right to refuse medical treatment as Wicks observed that the right to refuse life-saving medical treatment which she described as ‘a passive, voluntary euthanasia’ has its basis under ECHR article 2(1).³¹⁴ She has indicated that the objective of article 2(1) is to protect a person against being intentionally killed by others, and for passive euthanasia there is no need for someone to hasten death, just a requirement for withholding treatment that is prolonging life.³¹⁵ Therefore, because there is no positive obligation to prolong the patient’s life or a duty to impose on the person to live, it seems that article 2 is not breached or violated by a competent adult’s refusal of medical treatment.³¹⁶ English law³¹⁷ still does not recognise the act of active euthanasia, but it has for a long time accepted the right of the patient to refuse medical treatment under common law as in the case of *Re T(Adult: Refusal of Medical Treatment)*,³¹⁸ which will be referred to in Chapter three.

Other ECHR articles that are applicable to patients’ affairs include Article 3, which states that: ‘No one shall be subjected to torture or to inhuman or degrading treatment or

³¹⁰For example, *R (on the application of Purdy) v the Director of Public Prosecutions* [2009] UKHL 45 and *R (on the application of Nicklinson) v Ministry of Justice* [2014] UKSC 3.

³¹¹For example, *R v Human Fertilisation and Embryology Authority Ex p. Blood* [1999] Fam. 151 and *Evans v United Kingdom* (6339/05)(2008) 46 E.H.R.R. 34.

³¹²*Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

³¹³ECHR1950.

³¹⁴E Wicks ‘The Right to Refuse Medical Treatment under the European Convention on Human Rights’ (2001) 9 *Med Law Rev* 17-40 p. 20.

³¹⁵*Ibid.*

³¹⁶*Ibid.* p. 21.

³¹⁷For further details about some case law that considered ECHR, see C Yeo ‘Human Rights, Expulsion and medical treatment cases: a Review’ at <https://www.freemovement.org.uk/human-rights-expulsion-and-medical-treatment-cases-a-review/> (accessed 18/06/2015).

³¹⁸*Re T(Adult: Refusal of Medical Treatment)* [1993] Fam 95, Staughton LJ stated that: ‘[A]n adult whose mental capacity is unimpaired has the right to decide for herself whether she will or will not receive medical or surgical treatment, even in circumstances where she is likely or even certain to die in the absence of treatment’. p. 120-121.

punishment.³¹⁹ It is illegal to perform an operation or treatment on a competent patient without his valid consent under UK law and such an act might also be a breach of the patient's rights under Article 3.³²⁰ So, article 3 could also be seen as protecting the patient from being subjected to any medical treatment that he does not want, again supporting the patient's autonomy in deciding whether or not to accept treatment.³²¹

Article 8(1) states that; 'Everyone has the right to respect for his private and family life, his home and his correspondence.'³²² This article protects a person's 'physical integrity' as this can be seen as a part of the right to respect the private life of the patient:

'In the sphere of medical treatment, the refusal to accept a particular treatment might, inevitably, lead to a fatal outcome, yet the imposition of medical treatment, without the consent of a mentally competent adult patient, would interfere with a person's physical integrity in a manner capable of engaging the rights protected under Article 8 § 1 of the Convention.'³²³

In the recent case of *Montgomery*, the Supreme Court considered the notion of patients' rights and their protection by human rights' declarations, stating that

'Under the stimulus of the Human Rights Act 1998, the courts have become increasingly conscious of the extent to which the common law reflects fundamental values. As Lord Scarman pointed out in *Sidaway's* case, these include the value of self-determination.... As well as underlying aspects of the common law, that value also underlies the right to respect for private life protected by article 8 of the European Convention on Human Rights. The resulting duty to involve the patient in decisions relating to her treatment has been recognised in judgments of the European Court of Human Rights... as well as in a number of decisions of courts in the United Kingdom.'³²⁴(Original emphasis).

However, the Supreme Court also stressed that the value of patients' rights is recognised by English common law. Therefore, while acknowledging the influence of the ECHR, its Articles were not directly applied and in fact rather more attention was paid to national medical regulations and standards, such as those of the General Medical Council (GMC),³²⁵ rather than to the ECHR.

³¹⁹ ECHR 1950

³²⁰ For example, *Herczegfalvy v Austria* (Application no. 10533/83) (1993) 15 E.H.R.R. 437

³²¹ J Herring *Medical Law and Ethics* p. 187.

³²² ECHR1950.

³²³ *Pretty v United Kingdom* (Application no. 2346/02) (2002) 35 E.H.R.R. 1. para 63.

³²⁴ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 80.

³²⁵ The GMC is the responsible body for the registration of medical practitioners, their affairs, licences and setting standards for doctors in the UK at <http://www.gmc-uk.org/about/role.asp> (accessed 19/06/2015).

In fact, it is also important to note that Article 8 is not an unlimited right, it is a qualified right. Thus, such a right can be lawfully limited; this limitation must have a balance between the interests of the individual and the community as a whole. Therefore, that limitation must be in compliance with the law and it is necessary to consider that it may include the prevention of crimes or protection of the freedom and rights of others.³²⁶ Similarly, nonetheless, Article 10 has granted everyone the right of the freedom of expression, for example to hold an opinion and to receive information,³²⁷ but it is also a qualified right. This, I would argue, is in line with the earlier discussion that individuals do not have unlimited rights and the rights of others may need to be weighed in the balance.

In conclusion, it can be said that the ECHR and decisions of the European Court of Human Rights, as fundamental international principles, underpin respect for individual autonomy, although this is not without limitation. It can be said that the influence of the ECHR law on the content and application of English law is therefore an important external influence.³²⁸

4.2. English law and medical ethics

English law has been based on and influenced by a number of different sources as mentioned above, which obviously may show why English law may also have been influenced by medical ethics. It has been suggested that the influence of the recognition of respect for patient autonomy that has been shown in medical ethics has also been influenced in its turn by greater recognition of human rights and freedoms and contributed to the fading of the traditional paternalistic approach to healthcare.³²⁹

In term of considering medical ethics and law it seems that ‘there are a series of tensions and discrepancies between what is ‘legal’ and what is ‘ethical’ in the context of medical treatment, which may be confusing for healthcare professionals and patients alike.’³³⁰ This kind of tension seems to occur because the requirements of the law and the requirements of ethical principles in a specific medical matter may differ. It has been suggested that it is likely that ethical standards may require more than what the law asks for. An example of that may include information disclosure for consent to treatment where medical ethics (such

³²⁶ For example, L Kiestra *The Impact of the European Convention on Human Rights on Private International Law* (Asser Press 2014) p. 173 and S Harris-Short, J Miles, R George *Family Law: Text, Cases, and Materials* (3rd ed OUP 2015) p. 8.

³²⁷ ECHR1950.

³²⁸ E Wicks ‘The Right to Refuse Medical Treatment under the European Convention on Human Rights’ p. 39-40.

³²⁹ S McLean *Autonomy, Consent and the Law* p. 7.

³³⁰ E Jackson ‘The Relationship between Medical Law and Good Medical Ethics’ (2015) 41 *J Med Ethics* 95-98 p. 95.

as, the notion of full information disclosure) may demand more information than what the law has considered as sufficient.³³¹

This can be observed in the GMC guideline which has acknowledged and recognised some ethical principles that the law may not require. For example, the issue of how doctors should present information to the patient. ‘Consent: patients and doctors making decisions together’ guidance advised doctors to provide:

‘Clear, accurate information about the risks of any proposed investigation or treatment, presented in a way patients can understand, can help them make informed decisions. The amount of information about risk that you should share with patients will depend on the individual patient and what they want or need to know. Your discussions with patients should focus on their individual situation and the risk to them.’³³²

In another other section, the guidance requires doctors to inform the patient about risks, saying that doctors ‘...must tell patients if an investigation or treatment might result in a *serious adverse outcome*, even if the likelihood is very small. You should also tell patients about less serious side effects or complications if they occur frequently...’³³³ (Emphasis added). Interestingly, the guidance does not leave the phrase ‘*a serious adverse outcome*’ unexplained; in its endnote it is explained that: ‘An adverse outcome resulting in death, permanent or long-term physical disability or disfigurement, medium or long-term pain, or admission to hospital; or other outcomes with a long-term or permanent effect on a patient’s employment, social or personal life.’³³⁴ This seems to be a good example of a situation where the GMC ethical guideline arguably requires more from doctors than is demanded by law.³³⁵

Despite the seemingly higher standard set by the GMC guideline, the standard of information disclosure that will be examined in the following Chapters is the standard that requires doctors to disclose sufficient and understandable information to enable a competent adult patient to be self-determining and to respect his/her autonomy. Thus, the ethical standard that has been proposed will be considered throughout the following Chapters to demonstrate if the law has met such a requirement or if the law has required less or more than this. Another example of a tension between medical ethics, particularly the principle of respect for autonomy, and English law can be seen where a competent adult patient wishes to end his/her life with the active assistance of other (assisted suicide). The stance of the law as that

³³¹ Ibid.

³³² ‘Consent: patients and doctors making decisions together’ 2008 section 28.

³³³ Ibid. section 32.

³³⁴ Ibid. endnote no 9.

³³⁵ In *Montgomery* the Supreme Court cited with approval section 32 of ‘Consent: patients and doctors making decisions together’ 2008. *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 78.

it is illegal to do so.³³⁶ This is an issue that may arise in the medical context where patients with a terminal or debilitating illness are prevented from obtaining the legal assistance of doctors to end their own lives, despite expressing a clear and competent request on how they wish to die.³³⁷ This is despite the fact that, as will be discussed in more detail in Chapter three, a competent adult has a right to refuse treatment even if it is life-saving. McLean has said that ‘the law’s approach to end of life decision-making in terms of respect for autonomy is schizophrenic.’³³⁸ She then explained this by saying that: ‘On the one hand, the role of consent (or refusal) in respecting patient autonomy is trumpeted where a patient can achieve a chosen death by rejecting life-sustaining treatment. On the other, the autonomy of the individual is denied when that death requires active assistance.’³³⁹

While there are a vast number of justifications that have been given for allowing or refusing to permit a person to seek medical assistance to end their lives, these are beyond the scope of this thesis.³⁴⁰ However, it must be recognised that the harm principle discussed earlier could be used as a means of arguing from an ethical perspective for limitations on individual autonomy, such as permitting others to help end one’s life. Nevertheless, this example shows that the principle of respect for individual autonomy may produce contrary responses, and provoke debate in both ethics and law, even in decisions that might be regarded as so personal as the manner of one’s death.

In fact, the tensions between ethics and law can arise in many cases, but courts always have to consider and judge the matter based on legal principles rather than ethical principles. Nevertheless, while the courts are required to decide on the basis of legal principles, undoubtedly they are influenced by ethical principles more or less consciously.³⁴¹ It was recognised by Lord Coleridge over a hundred years ago that ‘it would not be correct to say that every moral obligation involves a legal duty; but every legal duty is founded on a moral

³³⁶ SA1961 (as amended) section 2.

³³⁷ E Jackson *Medical Law Text, Cases and Materials* p. 874-876.

³³⁸ S McLean *Autonomy, Consent and the Law* p. 127.

³³⁹ *Ibid.*

³⁴⁰ For examples, D Jeffrey *Against Physician Assisted Suicide: A Palliative Care Perspective* (1st ed Adcliffe 2008), C Paterson *Assisted Suicide and Euthanasia: A Natural Law Ethics Approach (Live Questions in Ethics and Moral Philosophy)* (Ashgate 2008), S McLean *Assisted Dying: Reflections on the Need for Law Reform* (1st ed Routledge/Cavendish 2007), D Shaw ‘The Body as Unwarranted Life Support: A New Perspective on Euthanasia.’ (2007) 33 *J Med Ethics* 519-521, H McLachlan ‘Shaw’s New Perspective on Euthanasia Killing of Patients? No: The Rejection of Maybe. Physician-assisted Suicide and the Assisted Suicide and the Killing of People?’ (2010) 36 *J Med Ethics* 306-309 and D Chao *et al.* ‘Euthanasia revisited’ (2002) 19(2) *Family Practice* 128-134.

³⁴¹ P Winfield ‘Ethics in English Case Law’ (1931) 45(1) *Harvard Law Review* 112-135 p. 132-135.

obligation. A legal common law duty is nothing else than the enforcing by law of that which is a moral obligation without legal enforcement.³⁴²

The potential conflict between ethical and legal principles has been specifically considered by some case law. A notable example is *Re A (Children) (Conjoined Twins: Surgical Separation)*.³⁴³ The case involved conjoined twins, where J was stronger than M and could live independently but M relied on the organs of her sister. Medical evidence showed that, if the twins were left as they were, M's demands on J's body would strain J, so both would die. However, if the separation operation was performed, M would inevitably die, whereas for J there was a strong chance to stay alive independently. The children's parents refused to give consent for the operation. Doctors then sought a court declaration that it would be lawful to operate on the conjoined twins. The declaration was granted by the High Court but the decision was appealed. The Court of Appeal dismissed the appeal.³⁴⁴ It has been said that in *Re A* the question of both medicine and ethics came together before a court of law.³⁴⁵ Ward LJ has observed the difficulty of the issue; he stated that:

‘I freely confess to having found it exceptionally difficult to decide—difficult because of the scale of the tragedy for the parents and the twins, difficult for the seemingly irreconcilable conflicts of moral and ethical values and difficult because the search for settled legal principle has been especially arduous and conducted under real pressure of time.’³⁴⁶

The Court of Appeal acknowledged the matter of ethics in the case, but sought to distance itself from the ethical debates.³⁴⁷ Thus, the focus of the Court of Appeal was to say that it was considering the matter on the legal principles not on ethical principles, as Ward LJ held that:

‘It is, however, important to stress the obvious. This court is a court of law, not of morals, and our task has been to find, and our duty is then to apply, the relevant principles of law to the situation before us—a situation which is quite unique.’³⁴⁸

Further, in relation to the matter which the Court of Appeal was considering, Ward LJ has made the position of the court clear as he has stated that: ‘Deciding disputed matters of life

³⁴² *R v Instan* [1893] 1 Q.B. 450 p. 453.

³⁴³ *Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam. 147.

³⁴⁴ *Ibid.*

³⁴⁵ M Brazier and S Ost *Bioethics, Medicine and the Criminal Law Medicine and Bioethics in the Theatre of the Criminal Process Volume 3* (1st ed CUP 2013) p. 163.

³⁴⁶ *Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam. 147 p. 155.

³⁴⁷ K Veitch *The Jurisdiction of Medical Law* (Ashgate 2007) p. 136-137.

³⁴⁸ *Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam. 147 p. 155.

and death is surely and pre-eminently a matter for a court of law to judge. That is what courts are here for.³⁴⁹

Nevertheless, although Ward LJ seems very clearly to hold the view that law should not be engaged in making decisions on ethical rather than legal principles, Brazier and Ost have claimed that Ward LJ in his distinction between law and ethics was misleading himself. They have stated that: ‘The Court of Appeal in *Re A* was, like it or not, a court of morals.’³⁵⁰ Brazier and Ost then have argued that: ‘But in its [the Court of Appeal] moral reasoning, bioethics played a role subsidiary to that of older and more generalised notions of morals and moral philosophy, and even theology.’³⁵¹

In conclusion, it can be said that, although the UK courts may stress that their roles are to ground the judgment on legal principles rather than ethical principles, it is impossible to entirely divorce law from ethical considerations since they deal with all issues of life about which an ethical perspective can always be taken. Thus, the courts may be in a position where they are able to choose what is the most appropriate principle or view that they should adopt, or to develop the law in order to reflect changing social views, including views on ethics. It is interesting to note here that in fact, such conflict and tension between ethics and law would not occur in Saudi Arabian courts, as the sources and foundations for both ethics and laws are the same (Islamic *Sharia*). This will be explored in Chapters two and four.

Arguably, as will be discussed in Chapter three it seems that the UK courts in recent times have begun to pay more attention to some of the medical ethics principles, for example respect for patient autonomy. This may be illustrated by a significant change in the way English courts protect the patient’s autonomy through the law relating to information disclosure.

Thus, it can be said that English law is not unaware of the need to consider ethical principles.³⁵² One of the notable cases for this thesis is *Sidaway v Bethlem Royal Hospital Governors*.³⁵³ *Sidaway* dealt with the issue of the proper legal standard for information disclosure which raised an issue that had become increasingly important in medical ethics,

³⁴⁹ *Ibid.* p. 174.

³⁵⁰ M Brazier and S Ost *Bioethics, Medicine and the Criminal Law Medicine and Bioethics in the Theatre of the Criminal Process Volume 3* p. 163.

³⁵¹ *Ibid.*

³⁵² For example, P Winfield ‘Ethics in English Case Law’.

³⁵³ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 AC 871.

the principle of respect for patient autonomy.³⁵⁴ Miola has noticed that the issue of information disclosure was significant in *Sidaway* because: firstly, in 1985 when the judgment of *Sidaway* was pronounced ‘...it might have been expected that the medical ethics renaissance would have started to have had an effect on the courts.’³⁵⁵ Secondly, it was for the first time that the House of Lords in *Sidaway* ‘...has dealt with a non-negligence case, and the issue was, in substance if not in form, more concerned with ethics than technical medical practice.’³⁵⁶ As will be discussed in depth in Chapter three, the majority of judges in *Sidaway* paid attention to consider the notion of patients’ self-determination to be informed.

Sidaway set out a number of different approaches that the law could adopt to setting the standard of information disclosure, which will be discussed in the Chapter three. However, it is worth noting here that this case was subsequently used to support an approach to information disclosure based on a professional standard, with liability largely depending on evidence from the profession about what information ought to be disclosed. It will be argued that since this case was heard, as in medical ethics, the law has shown an increased support for the principle of respect for autonomy in determining the duties of the medical profession. This can be seen, for example in *Chester v Afshar*.³⁵⁷ In this case, the judiciary placed greater emphasis on the importance of respect for patient autonomy, for example Lord Steyn cited in *Chester* Dworkin’s view in his book *Life’s Dominion: An Argument about Abortion, Euthanasia and Individual Freedom*,³⁵⁸ to emphasise and conclude His Lordship’s point of view regarding respect for the patient’s autonomy.

Finally, in the most recent significant case on information disclosure, *Montgomery*, it will be argued that respect for patient autonomy has become even more central and this has led the law to change its stance on the information disclosure standard, by moving from a professional based standard to a more patient-centred standard.³⁵⁹ Therefore, it can be said that the principle of respect for autonomy which has come to be central in medical ethics has also come to be regarded as central to the development of the approach of English law to information disclosure. It has been observed that consent to medical treatment not only has

³⁵⁴ R Crisp ‘Medical Negligence, Assault, Informed Consent, and Autonomy’ (1990) 17(1) *Journal of Law and Society* 77-89 p. 78-79.

³⁵⁵ J Miola *Medical Ethics and Medical Law a Symbiotic Relationship* (Hart 2007) p. 55.

³⁵⁶ *Ibid.*

³⁵⁷ *Chester v Afshar* [2004] UKHL 41.

³⁵⁸ *Ibid.* para 17 and 24.

³⁵⁹ R Griffith ‘Duty to Warn of Risks Moves to a Prudent Patient Approach’ (2015) 24(7) *British Journal of Nursing* 408-409.

an ethical role in medical treatment but also has an important legal role.³⁶⁰ This is due to the fact that ‘...rules about the provision of consent are a method of providing for the protection of the autonomy of the individual’.³⁶¹ Nevertheless, as will be discussed in Chapter three, there may still be a gap between what respect for autonomy might require in terms of the ethical ideal standard that has been proposed in this Chapter and what standard the law could and does impose. Based on the conclusions of this Chapter and Chapter three, Chapters two and four, will argue that Saudi Arabia can also develop its laws to protect patient autonomy better, but at the same time it needs respect its own ethical and religious traditions.

5. Conclusion

In this Chapter, I have presented a discussion of ethical principles from a Western perspective, particularly the principle of respect for autonomy and the notion of trust. This discussion has been provided in order to establish the basis for an examination of how English law has considered respect for the principle of autonomy in term of patients’ consent and information disclosure. This Chapter has addressed the theoretical basis for the autonomy principle and at its development and application in the area of medical practice. This has demonstrated that the principle of respect for autonomy, as discussed in medical ethics, has been strongly influenced by philosophical writings, such as those of Kant and Mill. It has been argued that, although the concept of autonomy remains subject to differing interpretations, it is a fundamental concern of medical ethics and it has assumed particular significance in recent medical ethics discussion. The principle of respect for autonomy places ethical duties on doctors to respect patients’ choices and to provide patients with understandable, sufficient and relevant information. Thus, the proposed ethical standard requires doctors to disclose sufficient and understandable information to enable a competent adult patient to be self-determining and to respect his/her autonomy.

It has also shown that another approach to ethical duties in healthcare that is of relevance to provision of information is that of trust. There clearly is a relationship between trust and respect for autonomy, in that in order to be able to rely on information to arrive at choice, there needs to be an element of trust in the person providing information. Similarly, for a trust relationship to arise, it has been argued that this requires patients to feel that their wishes will be respected, although this is not a universally held view. However, the thesis has argued that the notion of trust as above discussed would not sufficiently protect patients, as despite

³⁶⁰S McLean and G Maher *Medicine, Morals and the Law* (Gower 1983) p. 79.

³⁶¹ *Ibid.*

attempts to re-evaluate the notion of trust, at its heart trust in this context relies on an imbalance of power. This imbalance is something that respect for autonomy can and, I argue should, be used to redress. It has been shown that Western medical ethics have moved away from a paternalistic approach to a more individualistic one based on a patient's right to make treatment decisions, and this is an approach I endorse. Nevertheless, the thesis will revisit the principle of respect for autonomy and the notion of trust in the medical ethics context in Chapters two and four, to consider how Islamic *Sharia* and Saudi Arabian laws have interpreted them since it will be argued that has had an effect on the development of the legal approach to information disclosure and consent in Saudi Arabia.

Finally, to provide a comparison between the way in which law has developed in Saudi Arabia and England, the major sources of English law have been outlined. The relationship between the ethical principle of respect for autonomy and the law's approach to this in the area of information disclosure has also been introduced and this will be examined further in Chapter three.

It will discuss how the principle of respect for autonomy has attained recognition as forming a central part of the legal responsibilities of doctors towards patients. This has been achieved through the legal doctrine of consent to medical treatment. Kennedy and Grubb have argued that the legal concept of consent is the law's reflection of the ethical principle of respect for individual autonomy.³⁶² It has been said that '[t]he law therefore hands the responsibility for protecting and enhancing patient autonomy to the doctrine of consent'.³⁶³ Indeed, as McLean observes, '[i]t might, therefore, reasonably be assumed that the growing acceptance of the value of autonomy has been paralleled and enhanced by an increased legal focus on a tightly drawn and coherent doctrine of consent....'³⁶⁴ The legal doctrine of consent, therefore, promotes patient autonomy by seeking to protect people from any physical intervention they have not agreed to.³⁶⁵ The competent adult is generally free to make a decision and act as he or she chooses, provided that his or her decisions do not cause significant harm to others in the eyes of the law, and that decision must be respected.³⁶⁶ In terms of medical treatment, this means that a legally valid consent to treatment must be obtained.³⁶⁷ It can be concluded that 'the legal rules of consent are founded upon the right to autonomy and the principle of

³⁶²J Kennedy and A Grubb *Medical law* (3rded Butterworths 2000) p. 575.

³⁶³S McLean *Autonomy, Consent and the Law* p. 58.

³⁶⁴*Ibid.*

³⁶⁵A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge*. p. 150.

³⁶⁶S McLean *Autonomy, Consent and the Law* p. 214.

³⁶⁷See for example, *Re T (Adult: Refusal of Medical Treatment)* [1993] fam 95 and *S v McC: W v W* [1972] AC 24.

(respect for) autonomy'.³⁶⁸ Nevertheless, the question remains: in what ways has English law recognised this principle of respect for autonomy? This will be considered in detail in the Chapter three, focusing on information disclosure. In the light of what has been argued are the central features of respect for autonomy in this Chapter, the extent to which the law provides adequate protection will be evaluated. But before turning to that, in the next Chapter the thesis will examine the same issues that have been discussed in this Chapter focusing on Islamic *Sharia* and Saudi Arabian law perspectives.

³⁶⁸ A MacLean 'Now You See It, Now You Don't: Consent and the Legal Protection of Autonomy.' (2000) 17(3) *Journal of Applied Philosophy* 277–288 p. 277.

Chapter two: Islamic *Sharia* and Saudi Arabia medical ethics and law

1. Preface

In Chapter one, the thesis discussed the issue of Western medical ethics in relation to competent adult patients' consent and information disclosure. It was concluded that full information disclosure might seem to be an ethical ideal to protect individual autonomy, but that it would be difficult to achieve in practice and may not, in any case, meet the intended aim. Therefore, I have proposed an ethical standard that requires doctors to disclose sufficient and understandable information to enable competent adult patients to be self-determining and to respect their autonomy. This proposed ethical standard will be examined against English law in Chapter three and will be examined against Saudi Arabian medical law in Chapter four, to demonstrate whether the current legal standard of information disclosure in both jurisdictions can meet it.

In this Chapter and Chapter four the thesis will consider the approaches that have been adopted in both Islamic *Sharia* (in respect of ethical principles) and Saudi Arabian law (in respect of legal obligations). An evaluation of whether Saudi Arabian ethical and legal approaches are different to those of Western ethics and English law will be made. Based on the conclusions reached, a proposal for developing Saudi Arabian law will be provided in the Concluding Chapter. As Islamic *Sharia* law permits some lessons to be learned from the approaches of other jurisdictions, provided that any changes are not in conflict with Islamic *Sharia* principles, the Concluding Chapter will assess what, if anything, Islamic *Sharia* law can learn from the English law experience. It should be noted that since the issue of information disclosure in medical treatment has not yet been widely discussed by Muslim scholars or in Saudi Arabian medical law, there are limited ethical and legal sources and references. Nevertheless, I have sought to gather such information as is available in both Arabic and English to present a comprehensive discussion and argument. The fact that the standard of care in information disclosure has suffered from a lack of consideration by Islamic *Sharia* and Saudi Arabian ethical and legal literature and regulations supports the point I have made that this area is one in need of examination.¹ In fact, such an absence I contend also has led to confusion among patients, lawyers and doctors as to what should be

¹ See for example, the recent Conference: 'The 1st Gulf Patient Rights Conference' <http://gulfpatientrights.net/en/home-page> (accessed 15/02/2016) which shows that the patients' rights become more central, for example the objectives of the Conference stated that: '1.Highlighting the current situation of knowledge and practice of patient rights in healthcare facilities. 2.Improving professional as well as public awareness of patient rights. 3.Ensuring implementation of "patient first" concept in legislation and practice. 4.Developing Gulf framework for patient rights through the issuance of "Riyadh Document of Patient Rights"...'.

considered and disclosed and in consequence a lack of respect for a patients' right to information. Thus, this issue should be discussed both to confirm that patients' autonomy and right to information should be more recognised and protected, and to show what role law can play to safeguard patients' rights by clarifying areas of doubt or insufficiency.

In this Chapter, the thesis will address both the Islamic *Sharia* and Saudi Arabian medical ethics perspectives on the principle of respect for autonomy. Thus, in order to understand the context of Islamic *Sharia* and medical ethics principles it is necessary first to explain Islamic *Sharia* sources and the relationship between Islamic *Sharia* (as the supreme and principal source of the country's culture and laws) and the Saudi Arabian legal system. After explaining this, the Chapter will turn to considering how that influence has been interpreted generally in terms of both medical ethics and laws in Saudi Arabia, and more specifically in relation to consent to treatment and information disclosure.

2. Islamic *Sharia*

In order to understand how Saudi Arabian law has been formulated and applied and how Islamic *Sharia* has dealt with medical ethics issues, the thesis will start by explaining Islamic *Sharia*'s sources and its relation to Saudi Arabian laws.

2.1. An overview of Islamic *Sharia*

To begin with, Islam as an Arabic term literally means submission to the will of Allah.² The Islamic religion is one of the major religions in the world; it has been said that, 'Islam continues to deeply influence the beliefs, values and customs'³ of almost 1.6 billion people around the world.⁴ Islam was founded by the Messenger Mohammad PBUH, who received the holy *Quran* from Allah. The holy *Quran* is believed by Muslims to contain Allah's holy words.⁵ However, Islam is not only a religion that aims to provide guidance and instruction on how to worship Allah, it is also a set of advice and rules which are applicable to all of humanity as well as all daily activities of Muslims.⁶ Hence, 'Islam is both a religion and a complete way of life. It is a universal religion comprising all nationalities of the world, holding no distinctions based on colour, race or ethnicity.'⁷

² B Lewis and B Churchill *Islam: The Religion and the People* (Pearson education LTD 2009) p. 7-8.

³ A Gatrad and A Sheikh 'Medical Ethics and Islam: Principles and Practice' (2001) 84 *Arch Dis Child* 72-75 p. 72.

⁴ 'The Future of the Global Muslim Population' Pew Research Centre at <http://www.pewforum.org/2011/01/27/the-future-of-the-global-muslim-population/> (accessed 25/06/2015).

⁵ A Reinhart 'Islamic Law as Islamic Ethics' (1983) 11(2) *the Journal of Religious Ethics* 186-203 p. 189.

⁶ A Afifi 'Biomedical Research Ethics: An Islamic View Part 1'. (2007) 5 *International Journal of Surgery* 292-296 p. 292.

⁷ S Akhmad and L Rosita 'Islamic Bioethics: The Art of Decision Making' (2012) 2(1) *Indonesian Journal of Legal and Forensic Sciences* 8-12 p. 8.

Sharia is an Arabic word which means the path or the way that the water is running through.⁸ Therefore, as has been said, ‘water symbolises the source of life, so the *Sharia* represents the source of Muslim existence.’⁹ The term Islamic *Sharia* or *Sharia* includes all aspects of the Islamic religion, including worship, prayers, faith, ethics, laws and so forth.¹⁰ However, Islamic *Sharia* has primary, secondary and supplementary sources.¹¹

2.2. The two primary sources of Islamic *Sharia*

Generally, the two primary sources of Islamic *Sharia* are applicable to almost all Islamic schools of thought. The foundation of Islamic *Sharia* is based on the two primary sources: the first is the holy *Quran*, which contains Allah’s words (6326 verses (*Ayah*) in 114 chapters (*Surah*)) and each chapter in the holy *Quran* is given a title.¹² The holy *Quran* mainly deals with matters such as Islamic faith¹³ and worship,¹⁴ along with narratives about some sciences¹⁵ and different ancient religious and historical texts (such as the story of Judaism, and Christianity). The holy *Quran* in its entirety is not a codified law but around 500 verses of the holy *Quran* deal with what are regarded as legal rulings.¹⁶ Hence, the *Quran*, as Reinhart observed:

‘[I]s a source of knowledge in the way that the entire corpus of legal precedent is for the common law tradition: not as much as an index of possible rulings as a quarry in which the astute inquirer can hope to find the building blocks for a morally valid, and therefore, true system of ethics.’¹⁷

The other primary source of Islamic *Sharia* is the Messenger Mohammad’s PBUH traditions, called in Arabic *Sunnah* - the term in Arabic means ‘a clear path’. *Sunnah* contains his PBUH sayings and actions together with lessons implied from his silent or tacit approval.¹⁸ Allah in more than one verse in the holy *Quran* gives the authority to the Messenger PBUH *Sunnah*

⁸ B Weiss *The Spirit of Islamic Law* (UGP 1998) p. 17.

⁹ A Siddiqui ‘Ethics in Islam: Key Concepts and Contemporary Challenges’ (1997) 26(4) *Journal of Moral Education* 423-443 p. 425.

¹⁰ A Borroni and C Tabor ‘Caveat Emptor’s Current Role in Louisiana and Islamic Law: Worlds Apart yet Surprisingly Close’ (2009) 2 (1) *Civ. L. Stud* 61-100 p. 65.

¹¹ For example, I Nyazee *Outlines of Islamic Jurisprudence* (Advance legal studies institute 2010) Chapter II.

¹² A Padel ‘Islamic Medical Ethics: A Primer.’ (2007) 21(3) *Bioethics* 169-178 p. 175.

¹³ The holy *Quran* in translation for example, states that: ‘the Messenger (Muhammad SAW) believes in what has been sent down to him from his Lord, and (so do) the believers. Each one believes in Allah, His Angels, His Books, and His Messengers. They say, “We make no distinction between one another of His Messengers”- and they say, “We hear, and we obey. (We seek) Your Forgiveness, our Lord, and to You is the return (of all).’ (CH2:285).

¹⁴ The holy *Quran* in translation for example, states that: ‘Be firm in devotion; give Zakat (the due share of your wealth for the welfare of others), and bow with those who bow (before God).’ (CH2:43).

¹⁵ Ibrahim A *Brief Illustrated Guide to Understanding Islam* (2nded Durussalam 1997) p. 14-16. For example, the organ of the universe, the holy *Quran* in translation states: ‘Do not these unbelievers see that the heavens and the earth were an integrated mass, then We split them and made every living thing from water? Will they not believe even then?’ (CH30:21).

¹⁶ G Bader ‘Islamic Law: Its Relation to Other Legal Systems’ (1978) 26(2) *American Journal of Comparative Law* 187- 198 p. 188.

¹⁷ A Reinhart ‘Islamic Law as Islamic Ethics’ p. 189.

¹⁸ M Kamali *Principles of Islamic Jurisprudence* (The Islamic Texts Society 2003) p. 58.

as a source of Islamic *Sharia*. The holy *Quran* in translation states ‘...and accept [Muslims] whatever the Noble Messenger gives you; and refrain from whatever he forbids you...’.¹⁹ The Messenger’s PBUH *Sunnah* was collected and recorded many years after his PBUH death by many Muslim scholars in several books, which were labelled and referred to by the name of the collector.²⁰ The most famous authentic collections for Islamic *Sunni* schools (discussed below) are: *Sahih Al Bukhari* and *Sahih Muslim*.²¹ The name of these two books literally mean: Al Bukhari’s collection²² and Muslim’s collection.²³

In general, *Sunnah* works in accordance with the holy *Quran* in three major ways:²⁴ (1) It may retell what has been mentioned in the holy *Quran*.²⁵ (2) It may explain a range of verses in the holy *Quran*.²⁶ (3) It may potentially and importantly encompass a ruling that the holy *Quran* is silent about.²⁷ Therefore, both the holy *Quran* and the *Sunnah* ‘have constituted a foundational resource for Muslim beliefs, values and practices.’²⁸

Based on Reinhart’s statement above, I would argue that Islamic *Sharia* and English common law can learn and benefit from each other’s experiences although they have different origins. As we have already seen, Islamic *Sharia* has no barriers to learning and exchanging some ideas from other legal systems’ experiences so long as they are not in conflict with its basic principles. Similarly, English common law has benefited from some of Islamic *Sharia* experiences. For example, English common law has adjusted, adopted and applied some of Islamic *Sharia* legal aspects, Makdisi has argued that:

‘The Islamic legal system was far superior to the primitive legal system of England before the birth of the common law. It was natural for the more primitive system to look to the more sophisticated one as it developed three institutions that played a major role in creating the common law. The action of debt, the assize of novel disseisin, and trial by jury introduced mechanisms for a more rational, sophisticated legal process that existed only in Islamic law at that time. Furthermore, the study of

¹⁹ The holy *Quran* in translation (CH59:7).

²⁰ For example, M Gulen *Messenger of God Muhammad: An Analysis of the Prophet’s Life* (2nd ed The Fountain 2005) chapter 11.

²¹ There are other collections for *Sunni* schools such as, *Sunan Ibn Majah*, *Muwatta Malik*, *Sunan Abi Dawud* etc.

²² M AlBukhari *Sahih Al Bukhari* at <http://sunnah.com/bukhari> (accessed 25/06/2015).

²³ M AlHajjaj *Sahih Muslim* at <http://sunnah.com/muslim> (accessed 25/06/2015).

²⁴ M Kamali *Principles of Islamic Jurisprudence* p. 81-84.

²⁵ For example, both the holy *Quran* and the *Sunnah* prohibited the crime of theft.

²⁶ For example, the holy *Quran* orders Muslims to pay *Zakat*. *Zakat* is an Islamic religious duty to pay a sum of money from the person’s income or wealth to the poor each year, but the holy *Quran* does not explain in detail the percentage, how it should be collected, from which kind of wealth should be taken and so forth. The *Sunnah* defined all of that in detail.

²⁷ For example, *Sunnah* stated the right of pre-emption (*Hiq al Shuf*) which the holy *Quran* remains silent about it.

²⁸ A Nanji ‘Medical Ethics and the Islamic Tradition’(1988) 13 *The Journal of Medicine and Philosophy* 257-275 p. 258.

the characteristics of the function and structure of Islamic law demonstrates its remarkable kinship with the common law in contrast to the civil law.²⁹

He concludes:

‘Finally, one cannot forget the opportunity for the transplant of these mechanisms from Islam through Sicily to Norman England in the twelfth century. Motive, method, and opportunity existed for King Henry II to adopt an Islamic approach to legal and administrative procedures. While it does not require a tremendous stretch of the imagination to envision the Islamic origins of the common law, it does require a willingness to revise traditional historical notions.’³⁰

Further it has been argued that English common law has been influenced by some Islamic *Sharia* jurisprudence (*Fiqh*) books which have had an impact on English legal writers and legal principles, for example during the 18th and 19th centuries while India (where Islam and Islamic law have been practised for a long time) was under British colonisation, some English’s writers and legal principles in England have been influenced by the Islamic *Hanafi* school³¹ as result of the translation of a huge part of scholar Ali al-Marghinani’s book *al-Hiddaya al-Marghinani (The Hedaya)*³² by Charles Hamilton.³³ Those examples and others³⁴ show with no doubt some influences of Islamic *Sharia* on English common law.

Clearly, there are some areas where Islamic *Sharia* and English law are unlike and cannot be in agreement such as the Islamic *Sharia* practice of punishment by death. Nonetheless, the focus here is on an area where both systems have traditionally applied the professional standard of care (in the UK, at least until the *Montgomery* case was decided)³⁵ and therefore, historically, have been broadly in agreement with each other.

For the purposes of this discussion, there are several interesting consequences of comparing and contrasting English and Saudi Arabian law in this area. First, this permits an analysis of the rationale(s) for the reliance of both systems on the professional standard. Second, analysis of the change of emphasis in English law allows exploration of the reasons for change and what influenced the Supreme Court’s decision. Whether or not the same (or similar) circumstances exist in Saudi Arabia will inform the extent to which, if at all, it would be feasible/acceptable to draft such a change into its law. The discussion in this Chapter of *Sharia* law and ethics will directly affect the concluding recommendations of the thesis.

²⁹ J Makdisi ‘The Islamic Origins of the Common Law’ (1999) 77 *North Carolina Law Review* 1635-1740 p. 1731

³⁰ *Ibid.*

³¹ See the school definition below in this Chapter.

³² J Strawson ‘Islamic Law and English Texts’ (1996) VI(1) *Law and Critique* 21-38 p. 26-27.

³³ Charles Hamilton (1752-1792) <http://www.newulsterbiography.co.uk/index.php/home/viewPerson/2072> (accessed 24/02/2016)

³⁴ M Gaudiosi ‘Influence of the Islamic Law of WAQF on the Development of the Trust in England: The Case of Merton College’.

³⁵ See Chapter three for further discussion.

Thus, I would argue that to learn some lessons from other legal systems' experiences is not simply to copy and paste their experiences or principles; rather, it is to take the best from them to be investigated, shaped, adjusted where necessary into a form that can be adopted and transplanted by the recipient jurisdiction.³⁶ Thus it can be said that it is not wrong or impractical to learn from other legal experiences.³⁷ For example, Messenger Mohammad PBUH said: 'A wise word is the lost property of the believer, so wherever he finds it, he has more right to it'.³⁸ Thus, where there is a principle or law or a piece of information or knowledge that is worthy and good for Muslims whoever has stated it, it should be considered and accepted as long as it is not in conflict with Islamic *Sharia* basic principles.³⁹

One of the common areas between Islamic *Sharia* and common law is the way in which its principles develop. As has been said in Chapter one, English law is a common law system which mainly relies on judges' interpretation, reasoning and precedent. This system allows for discussion of the reasoning of individual judges and enables analysis of the rationale for their decisions.

Arguably, this is similar to the way in which Muslim scholars study, investigate and consider an issue based on Islamic *Sharia* main sources. Those sources 'actually cover only a small part, or outline some basic principles of norms and values';⁴⁰ the rest is left to the interpretation of Muslim scholars who identify the way to understand and apply Islamic *Sharia* in different situations.⁴¹

Therefore, '[l]ike common law, Islamic law is not a written law. But whereas the rule of precedent makes common law a judicial law, the provisions of Islamic law are to be sought

³⁶ For example, Saudi Arabia has signed the Convention on the Elimination of All Forms of Discrimination against Women, with some reservations, because that is in conflict with some of its basic principles, <http://www.un.org/womenwatch/daw/cedaw/reservations-country.htm> (accessed 24/02/2016). See for examples, A Watson *Legal Transplants: An Approach to Comparative Law* (2nd ed UGP 1993) and A Watson 'Legal Change: Sources of Law and Legal Culture' (1983) 131(5) *University of Pennsylvania Law Review* 1121-1157.

³⁷ See for example, O Kahn-Freund 'On Uses and Misuses of Comparative Law' (1974) 37(1) *The Modern Law Review* 1-27. R Williams 'Archbishop's lecture - Civil and Religious Law in England: a Religious Perspective' <http://rowanwilliams.archbishopofcanterbury.org/articles.php/1137/archbishops-lecture-civil-and-religious-law-in-england-a-religious-perspective> (accessed 24/02/2016), C Hope and J Kirkup 'Muslims in Britain should be able to live under sharia, says top judge [Lord Phillips]' *The Telegraph* (in 03 Jul 2008) <http://www.telegraph.co.uk/news/uknews/2242340/Muslims-in-Britain-should-be-able-to-live-under-Sharia-law-says-top-judge.html> (accessed 24/02/2016) and J Bingham 'Islamic law is adopted by British legal chiefs' *The Telegraph* (in 22 March 2014) <http://www.telegraph.co.uk/news/religion/10716844/Islamic-law-is-adopted-by-British-legal-chiefs.html> (accessed 25/02/2016).

³⁸ M Majah *Sunan Ibn Majah* <http://sunnah.com/urn/1343070> (accessed 25/02/2016).

³⁹ GPSRI *fatwa* no 21010 <http://www.alifta.net/fatawa/fatawaDetails.aspx?View=Page&PageID=10414&PageNo=1&BookID=3&languageName=> (accessed 25/02/2016) (Arabic).

⁴⁰ A Siddiqui 'Ethics in Islam: Key Concepts and Contemporary Challenges' p. 425.

⁴¹ S El-Fishawy 'Contract and Litigation in Islamic Law' (1982) 76 *Proceedings of the Annual Meeting American Society of International Law* 62-65 p. 62.

first and foremost in the teachings of the authoritative jurists. It may therefore be called a lawyer's law if common law is a judge's law.⁴² While this quotation points to the differences between the two systems, it also highlights the similarities, in that interpretation and reasoning are needed in order to reach an appropriate conclusion. Certainly, Islamic law relies quite heavily on statute, but where there are no clear rules it is for that interpretation and reasoning to resolve any problems. Scholars interpret the main sources of Islamic *Sharia* and then extract their views, understanding and analysis from the main sources like the 'astute inquirer'⁴³ to establish and set Islamic *Sharia* principles that can be applied by Muslims or codified by a State.

Muslim scholars since the third century onward have understood the holy *Quran* as a guidance which shows the way to set ethical principles; by using that guidance, scholars seek to identify an act which is ethically valid and provide them with knowledge for the assessment of the acts 'the five rulings'.⁴⁴ Therefore, to examine whether an act is religiously, legally and ethical valid, scholars search for an indication in the holy *Quran* which will set the right religiously, legal and ethical place for the act and allow the scholar to be informed about the act's assessment.⁴⁵ Additionally, Muslim scholars, beside applying the holy *Quran*, also apply the Messenger PBUH traditions as religious, legal and ethical guidance. Thus, both the holy *Quran* and the the Messenger's traditions provide the basic principles and foundations of religious, legal and ethical guidance for Muslim scholars and the way that they set the Islamic *Sharia* principles.⁴⁶

After the holy *Quran* and the Messenger's PBUH *Sunnah* come (1) the secondary and (2) the supplementary sources of Islamic *Sharia*. The status and interpretation of these sources rely on the understanding of particular Islamic schools of thought. In order to appreciate why each Islamic school of thought has its own approach to secondary and supplementary sources, the main schools of thought will be outlined.

2.3. Islamic schools of thought

The secondary and supplementary sources of Islamic *Sharia* have developed during the history of Islam after the Messenger PBUH death. Their developments relied on Muslim scholars' and jurists' understanding and analysis of the primary sources of Islamic *Sharia*

⁴² G Bader 'Islamic Law: Its Relation to Other Legal Systems' p. 189.

⁴³ A Reinhart 'Islamic Law as Islamic Ethics' p. 189.

⁴⁴ See their explanations below in this Chapter.

⁴⁵ A Reinhart 'Islamic Law as Islamic Ethics' p. 191

⁴⁶ Ibid.

and how they are to be applied to new issues.⁴⁷ Islam has many schools of thought but the ones followed most by Muslims are the *Sunni* school, then the *Shiite* school.⁴⁸

First, the *Sunni* school gained its name due to its emphasis on the Messenger's PBUH *Sunnah* (traditions).⁴⁹ The *Sunni* school is followed by the majority of Muslims in the world and it bases its teaching and understanding on the holy *Quran*, Messenger's PBUH traditions and what his companions said.⁵⁰ Even within the *Sunni* school of thought, however, there are further divisions that apply their understanding broadly via two approaches. The first is known as the traditional approach, which firmly follows the Messenger's PBUH traditions. If there is no statement in the holy *Quran*, scholars and jurists do not go beyond the primary sources.⁵¹ In other words, generally their view must be based on a statement from the holy *Quran* or Messenger's PBUH traditions. *Sunni* schools following a traditional approach are: *Maliki* school, founded by scholar Malik ibn Anas (715-795),⁵² *Shafii* school, founded by scholar Mohammad AlShafii (767-820)⁵³ and *Hanbali* school, founded by scholar Ahmad ibn Hanbal (780-855).⁵⁴ As will be explained later, it is the *Hanbali* school which has traditionally been followed in Saudi Arabia and which formed the basis of Saudi Arabian jurisprudence from the formation of the State, although it appears that the exclusive use of the *Hanbali* approach may now no longer represent the way that laws will be developed in the future. The other approach, which should be mentioned for comparison, is known as the eliciting and analogical school, which relies on scholars' making arguments by analogy and by their understanding of and eliciting views about not only on the Islamic *Sharia* primary sources, but also on secondary sources.⁵⁵ In other words, if there is no clear statement by the holy *Quran* or the Messenger's PBUH traditions they apply their analogies to state their view regarding an issue. The *Sunni* school applying this approach is the *Hanafi* school, founded by scholar Abu Hanifah Numan ibn Thabit (702-767).⁵⁶

The second major school of thought is the *Shiite* school, which was formed based on the claim to support and follow the rule of the fourth Muslim Caliph, Ali ibn Abi Talib who

⁴⁷ A Philips *The Evaluation of Fiqh: Islamic law and the Madh-habs*. (International Islamic Publishing House 2006) at 73-85.

⁴⁸ Most of the other are minority schools, such as *Batiniyya*, *Qadiriyya*, *Zahiri*, *Zaidiyyah*, etc. For further information, P Bearman *The Islamic School of Law: Evolution, Devolution, and Progress (Harvard Series in Islamic Law)* (HUP 2006)

⁴⁹ K Armstrong *Islam a Short History* (The Modern Library, 2002) p. 63-65.

⁵⁰ *Ibid*.

⁵¹ B Weiss 'The Madhhab in Islamic Legal Theory' in P Bearman, R Peters and F Vogel (ed.) *The Islamic School of Law Evolution, Devolution and Progress*. (HUP 2005) 1-9 p. 2-5.

⁵² For further detail U Abd-Allah *Malik and Medina: Islamic Legal Reasoning in the Formative Period* (Brill 2012).

⁵³ A Philips *The evaluation of Fiqh: Islamic Law and the Madh-habs*. p.157-158.

⁵⁴ For further detail C Melchert *Ahmad ibn Hanbal* (Oneworld 2006).

⁵⁵ B Weiss 'The Madhhab in Islamic Legal Theory' p. 2-5.

⁵⁶ A Philips *The Evaluation of Fiqh: Islamic Law and the Madh-habs*. p. 154-155.

ruled after the assassination of the third Caliph, Uthman Ibn Affan, in 656 until 661.⁵⁷ The *Shiite* school strictly follows Imams⁵⁸ drawn from Caliph Ali's descendants and it is vital to the *Shiite* school to follow and respect those Imams and their views, as it is believed that those Imams are infallible, sinless and lawgivers.⁵⁹ This *Shiite* perspective is one of the main differences between it and the *Sunni* school, as the *Sunni* school believes that only Allah's Messengers (Moses, Jesus, Mohammad PBUH and so forth) are infallible, sinless and lawgivers, and no other people have that status. The *Shiite* school follows the holy *Quran* and Messenger's PBUH traditions, but based on their own sources and how their Imams have interpreted them.⁶⁰ The *Shiite* school has within it many schools of thought such as the *Imamate* school (twelve doctrines)⁶¹ and *Ismailism* school.⁶²

However, since Saudi Arabia is a majority *Sunni* country, it is not necessary to consider the divisions of the *Shiite* school in further detail. Instead, the following discussion on the secondary and supplementary sources of Islamic *Sharia* will focus on the *Sunni* school only.

2.4. The *Sunni* secondary sources

The secondary sources include what the majority of *Sunni* Muslim scholars agree on in respect of particular problems where there are no solutions for them in the primary sources. The tool for reaching agreement is through *Ijma* (consensus of opinion) and *Qiyas* (analogical reasoning).

The question arises as to who can determine the secondary sources of Islamic *Sharia*. Under Islamic teachings and among Muslim society, a scholar (*Mujtahed*) has a great and noble reputation and is given immense respect as a result of his knowledge.⁶³ It is believed that the scholar's deep knowledge and experience that he has gained by studying Islamic *Sharia* in mosques, schools and universities and teaching it, qualifies him to understand matters which require a kind of personal reasoning or 'utmost effort' (*Ijtihad*).⁶⁴ The scholar studies a new

⁵⁷ W Ende and U Steinbach *Islam in the World Today: A Handbook of Politics, Religion, Culture, and Society* (Cornell university, 2010) p. 12-15.

⁵⁸ In the *Shiite* school, the concept 'Imams' always refers to the Caliph Ali's descendants. In the *Sunni* school the concept of 'Imams' is a much broader one and it can be used as a title for a scholar, prayer leader, ruler etc.

⁵⁹ M Lippman, S McConville and M Yerushalmi *Islamic Criminal Law and Procedure* (1st ed Praeger 1988) p. 17-19.

⁶⁰ For more detail about *Shiite* school sources and ways to apply Islamic *Sharia*, H Nahim *The Division After Prophet Muhammad* (Xlibris Corporation, 2012).

⁶¹ For further detail J Subhani *The Doctrines of Shiism: A Compendium of Imami Beliefs and Practices* translated by R Shah-Kazemi (I.B. Tauris and Co Ltd, 2001).

⁶² For further detail F Daftary *The Ismailis: Their History and Doctrines* (1st ed CUP 1990).

⁶³ The holy *Quran* in translation states that 'Allah will exalt in degree those of you who believe, and those who have been granted knowledge...' (CH58:11).

⁶⁴ A *Mujtahed* 'must be a Muslim and a competent person of sound mind who has attained a level of intelligence competence that enables him to form an independent judgement.' M Kamali *Principles of Islamic Jurisprudence*. p. 476.

matter and offers his opinion according to Islamic jurisprudence in cases which are not dealt with specifically by the holy *Quran* or the Messenger's PBUH traditions.

Having done so, the scholar issues a declaration on the matter. Thus, it can be said that a declaration is the tool or device that presents the *Sunni* Muslim scholars' *Ijtihad*. Normally, Muslim scholars are answering a question that has been submitted to them and in this way issuing a declaration develops and formulates Islamic *Sharia* in different areas such as ethics and law.⁶⁵ The concept of a declaration has an important role in Muslim communities and has been applied broadly as a source for comparative legal studies by researchers and commentators.⁶⁶ Muslim scholars' declarations can be applied as the secondary sources of Islamic *Sharia* when their declarations are accepted as *Ijma* or based on *Qiyas*, which then become part of the law of the community and would be incorporated as part of the *Sharia*.⁶⁷

It should be noted that, if a declaration (*fatwa*) is issued by a single scholar to enforce or declare a principle that has been already stated by the holy *Quran* or the Messenger PBUH traditions or *Ijma* or *Qiyas* (for example, if the declaration (*fatwa*) says stealing other's goods is a crime of theft), in this case the *fatwa* should be followed because it is just an enforcement of an established principle. On the other hand, if the *fatwa* is issued by a single scholar on a matter that has no clear reference in the holy *Quran* or the Messenger PBUH traditions or *Ijma* or *Qiyas*, in this case his *fatwa* should not be strictly followed; it is a subject for debate and it can be overruled or changed by the scholar himself or challenged by other scholars. For example, before the consensus (*Ijma*) of the majority of Muslim scholars in the 1970s and 1980s to legalise organ donation and transplantation, there were different *fatawa* among scholars on these practices. This was because there was no straightforward reference for the lawfulness or unlawfulness for this new matter in the holy *Quran* or the Messenger PBUH traditions or *Ijma* or *Qiyas*. Hence, a single *fatwa* could be the subject of debate and challenge. However, once there was a consensus (*Ijma*), organ donation and transplantation are regarded as legal, since the majority agreement on this.⁶⁸

Accordingly, a single *fatwa* for a matter where there is no reference for it in holy *Quran* or the Messenger PBUH traditions or *Ijma* or *Qiyas*, can be challenged and changed by other scholars. Therefore, this differentiation and the use of the terms majority consensus (*Ijma*)

⁶⁵ A Padela 'Medical Ethics in Religious Traditions: A Study of Judaism, Catholicism, and Islam' (2006) 38 *JIMA* 106-117 p. 114.

⁶⁶ *Ibid.*

⁶⁷ D Pearl *A TextBook on Muslim Law* (2nd ed Croom Helm Ltd 1987) p. 14. See also G Hourani 'The Basis of Authority of Consensus in Sunnite Islam' (1964) 21 *Studia Islamica* 13-60.

⁶⁸ For further discussion, D Atighetch, *Islamic Bioethics: Problems and Perspectives*. (Springer, Vol 31 2009) p. 161-197.

or a single scholar's view should be borne in mind throughout this thesis. To complete the picture of Islamic *Sharia* sources the following part will discuss further the circumstances where Muslim scholars' views should be followed and cannot be changed.

1. *Ijma* (consensus of opinion)

Ijma is the consensus of the majority of qualified Muslim scholars regarding new legal, ethical, and other issues.⁶⁹ There are two approaches to identifying whether the resolution of an issue has been made by *Ijma*: it is either found that there has been a resolution in the scholarly heritages as they have agreed on one view on the same issue and that agreement has been recognised.⁷⁰ Alternatively, it may be considered to have been resolved through recently developed Islamic institutions; famous institutions now include the *Al Azhar* Mosque in Egypt, the GPSRI in Saudi Arabia, and the International Islamic *Fiqh* Academy (IIFA). However, of most relevance to this thesis is the role of the GPSRI and the IIFA. The GPSRI is the highest religious authority in Saudi Arabia. It was established in 1971 and it is responsible for issuing religious declarations in regard to a religious or a legal issue that has been submitted to it by the King's office or other authorities *etc.* The GPSRI's declarations can be enforced as a legal rule if the government has adopted them. I will revisit the GPSRI's role for legislation in Saudi Arabia later on in this Chapter. The IIFA was established in 1981 in Jeddah in Saudi Arabia, and it is composed of a scholar from each Islamic country and a country that has Muslims as a minority.⁷¹ One of the IIFA's aims is to make a study of new matters that arise for all Muslims and which require Muslim scholars to issue a declaration based on the majority consensus.⁷² In relation to this research, the thesis will use declarations that are issued by Saudi Arabia GPSRI as the highest religious authority in the country. It will also use the IIFA declarations as they are widely acknowledged in the country.

However, although the procedure of *Ijma* is to apply the Islamic *Sharia* to new legal or ethical matters that have arisen, the majority of Muslim scholars have to consider them and establish their views and they must search first for an answer in the holy *Quran*.⁷³ If there is no clear statement in it, they have to search through the Messenger's PBUH traditions. If there is no clear sign there either, they then must apply their knowledge and understanding and agree on a consensus view, ensuring that view does not conflict with other Islamic basic

⁶⁹ M Kamali *Principles of Islamic Jurisprudence* p. 228-232.

⁷⁰ M Farooq *Toward Our Reformation: From Legalism to Value-Oriented Islamic Law and Jurisprudence* (The international Institute of Islamic Thought 2011) p. 141-167.

⁷¹ E Ihsanoglu *The Islamic World in the New Century: The Organisation of the Islamic Conference, 1969-2009* (1st ed C Hurst & Co Publishers Ltd 2010) p. 91-93.

⁷² *Ibid.*

⁷³ A Reinhart 'Islamic Law as Islamic Ethics' p. 190-191.

principles.⁷⁴ Thereafter, that view, agreed by the majority of Muslim scholars (*Mujtahedeen*), becomes a common principle adopted by Muslim nations. It must be respected by Muslims and cannot be changed.⁷⁵

2. *Qiyas* (analogical reasoning)

Qiyas – a singular word – means comparing something to something else that has the same characteristics. If there is no clear statement in the holy *Quran* or the Messenger's PBUH traditions, or there is no *Ijma*, Muslim scholars have to identify a 'correlation with an already accepted norm.'⁷⁶ For example, the holy *Quran* states that the use of wine is prohibited,⁷⁷ therefore, as substances such as heroin or cannabis cause the same kind of intoxicating condition, based on the principle of *Qiyas*, these kinds of drugs are banned.⁷⁸ However, a *Qiyas* is different from *Ijma* as follows: 1) *Qiyas* can be issued by one scholar or more, whereas *Ijma* has to be issued by a majority of Muslim scholars, 2) *Qiyas* is a way to classify or accommodate a new case within an old or existing approach to an issue which has the same character, but *Ijma* is for establishing or introducing a new rule to Islamic *Sharia*.⁷⁹ However, *Qiyas* like *Ijma* must be respected and cannot be changed.⁸⁰

After having discussed the secondary sources of *Sunni* Islamic *Sharia* (*Ijma* and *Qiyas*), now an outline of supplementary sources and principles will be presented:

2.5. The *Sunni* supplementary sources

These sources are also considered and applied by Muslim scholars when making their declarations (*Fatawa*).

1. Revealed laws preceding the Islamic *Sharia*. This source of Islamic *Sharia* shows that Islam has a relationship to previous divine beliefs, specifically Judaism and Christianity; many verses in the holy *Quran* have established this, such as in the areas of crimes and punishments, where the holy *Quran* in translation declares:

‘And there (in the Torah [Bible]) We [Allah] had ordained for them a life for a life, and an eye for an eye, and a nose for a nose, and an ear for an ear, and a tooth for a tooth, and for wounds retribution, though he who forgoes it out of

⁷⁴ M Kamali *Principles of Islamic Jurisprudence* p. 231-232.

⁷⁵ A Siddiqui 'Ethics in Islam: Key Concepts and Contemporary Challenges' p. 426 and M Kamali *Principles of Islamic Jurisprudence* p. 232.

⁷⁶ A Siddiqui 'Ethics in Islam: Key Concepts and Contemporary Challenges' p. 426.

⁷⁷ The holy *Quran* in translation states that: 'O People who Believe! Wine (all intoxicants), and gambling, and idols, and the darts are impure – the works of Satan, therefore keep avoiding them so that you may succeed.' (CH5:90).

⁷⁸ A Siddiqui 'Ethics in Islam: Key Concepts and Contemporary Challenges' p. 426.

⁷⁹ M Lippman, S McConville and M Yerushalmi *Islamic Criminal Law and Procedure* p. 31-32.

⁸⁰ M Kamali *Principles of Islamic Jurisprudence* p.298-301.

charity, atones for his sins. And those who do not judge by God's revelations are unjust.⁸¹

2. Every declaration issued by the Messenger's PBUH companions after the Messenger's PBUH death regarding any matters that have not been addressed by Islamic *Sharia* primary sources. For example, there was only one call for Muslims to attend the speech and prayer for Friday prayer (*Jumuah*) which was set by the Messenger PBUH. Caliph Uthman Ibn Affan, one of the Messenger's PBUH closest companions, who ruled from 644 to 655 (many years after the Messenger's PBUH death), added a first call to be performed an hour before the existing one.⁸² The reason for the additional call was to give plenty of time to Muslims who are far away from the mosques or at work to be prepared and enabled to gather with those who are already in the mosque to listen to the speech then pray.⁸³ This declaration set by Caliph Uthman is still in practice and regarded as obligatory.

3. *Istihsan* (equity in Islamic law) means for Muslim scholars the need to find a just solution for a new matter that has no reference in the Islamic *Sharia* primary sources.⁸⁴

4. *Maslahah Mursalah* (consideration of public interest), such as the establishment of taxation on foreign goods, to protect local producers.⁸⁵

5. *Urf* (custom) are 'recurring practices that are acceptable to people of sound nature',⁸⁶ such as the system of *Diyah* (blood money), which existed before the Islamic era and has been adopted by Islamic *Sharia* with some amendments.⁸⁷

6. *Istishab* (presumption of continuity), such as the continuation of the validity of a contract between parties which has been established for a long time, unless they – or one of them – have proven that the contract is no longer valid.⁸⁸

7. *Sadd al-Dharai* (blocking the means), which basically means banning a lawful action in order to prevent an illegal action, such as control of some types of trades,⁸⁹ for example, selling grapes to wine producers: Without the rule of *Sadd al-Dharai*, selling grapes to wine producers would be lawful, but because making and using alcohol are illegal for Muslims

⁸¹ The holy *Quran* in translation (CH5:45).

⁸² Scholar Abdalaziz bin Baz (Q&A) at <http://www.binbaz.org.sa/node/1322> (accessed 26/06/2015) (Arabic).

⁸³ *Ibid.*

⁸⁴ A Yacoub *The Fiqh of Medicine Response in Islamic Jurisprudence to Development in Medical Science* p. 26.

⁸⁵ M Kamali *Principles of Islamic Jurisprudence* p. 351.

⁸⁶ *Ibid.* p. 396.

⁸⁷ A Yacoub *The Fiqh of Medicine Response in Islamic Jurisprudence to Development in Medical Science* p. 26.

⁸⁸ M Kamali *Principles of Islamic Jurisprudence* p.384.

⁸⁹ *Ibid.* p.397.

under Islamic *Sharia*, Muslims should not support those who make it by selling them grapes.⁹⁰

It will be seen that Islamic *Sharia* has a rich and wide range of sources that have been used to establish principles to govern and guide Muslims. It relies on long respected beliefs and traditions but also allows for principles to be adapted and developed, provided that this does not conflict with core values. After having presented Islamic *Sharia* sources, based on the *Sunni* school, and explained the possibility that Islamic *Sharia* can learn some lessons from English law experiences, the discussion can now turn to considering how Islamic *Sharia* has influenced Saudi Arabian law and how it is relevant to the formation and development of Saudi Arabian laws.

3. The relationship between Islamic *Sharia* and the Saudi Arabian's legal system

3.1. A historical background

The current Kingdom of Saudi Arabia was established on 1932,⁹¹ on the Arabian Peninsula, the birthplace of Islam. It is where the divine book, the holy *Quran*, was revealed to the Messenger PBUH, who was born, became a messenger, died and was buried in this area.⁹² Saudi Arabia contains the two holiest places for all Muslims: the holy city of Makkah alMukarrama, which has the grand mosque, and the holy city of alMadinah alMunawwarah, which has the Messenger's PBUH home, mosque, and burial place.⁹³ As the Kingdom of Saudi Arabia is such a place of holiness for Islam, it is not surprising that '[t]he legal system of Saudi Arabia is an exceptional one in the world of Islam, where the *Sharia* is applied'.⁹⁴ This is illustrated by the fact that, on the day of its establishment, the founder of the current Kingdom (King Abdulaziz Al-Saud⁹⁵) declared that the Kingdom would be driven by, and would conduct itself according to, the teachings of the Islamic *Sharia*.⁹⁶ King Abdulaziz selected one of the Islamic *Sunni* schools, the *Hanbali* school, to be the main authority for Saudi Arabia's lawmakers and for its judicial system.⁹⁷ Therefore, since that time, most of

⁹⁰For example, GPSRI declaration no 17853 at <http://www.alifta.net/Fatawa/FatawaChapters.aspx?language=en&View=Page&PageNo=1&FromMoeasrID=11037&PageID=4643&BookID=7> (accessed 25/06/2015).

⁹¹J Wynbrandt *A Brief History of Saudi Arabia* (2nd ed Infobase Publishing 2010) p. 187.

⁹²*Ibid.* p. 24.

⁹³S AlMubarakpuri *The Sealed Nectar - Biography of the Noble Messenger* - p.71, 86 and 558.

⁹⁴R Peters *Crime and Punishment in Islamic Law Theory and Practice from the Sixteenth to the Twenty-First Century* (1st ed CUP 2005) p. 184.

⁹⁵King Abdul Aziz was born in 1876, and in 1932 he established the Kingdom. He died in 1953. 'History of The Kingdom of Saudi Arabia' at <http://www.mofa.gov.sa/sites/mofaen/ServicesAndInformation/aboutKingDom/Pages/CountryDevelopment36143.aspx> (accessed 11/09/2015).

⁹⁶M Hanson 'The Influence of France Law on the Legal Development of Saudi Arabia' p. 274.

⁹⁷G Wash 'Islamic Law in Saudi Arabia: What Foreign Attorney's Should Know' (1991) 25 *Journal of International Economic Law* 131-170 p. 141.

Saudi Arabia's written laws and principles were based on and applied according to the *Hanbali* school of thought.⁹⁸ Notwithstanding that, it could be argued that the policy of Saudi Arabian lawmakers has slightly changed recently. The BLG1992 did not mention a specific Islamic school of thought, but stated that: 'Government in the Kingdom of Saudi Arabia derives its authority from the Book of God and the *Sunnah* of the Messenger (PBUH), which are the ultimate sources of reference for this Law and the other laws of the State'.⁹⁹ This approach can also be seen in the Law of Procedure before *Sharia* Courts 2013 (LPSC2013): 'Courts shall apply to cases before them provisions of *Sharia* laws, in accordance with the *Quran* and *Sunnah* of the Messenger and laws promulgated by the State that do not conflict with the *Quran* and *Sunnah*...'.¹⁰⁰ It appears from this that Saudi Arabian legislators and courts are not restricted to applying a specific Islamic *Sunni* school of thought and can apply views from any Islamic *Sunni* school, not only from the *Hanbali* tradition.¹⁰¹ It also remains the case as a matter of general principle in Saudi Arabia that, in the event that no written laws or acts deal with specific or general matters, the courts and regulators have to apply Islamic *Sharia* sources.¹⁰² Therefore, in the Kingdom of Saudi Arabia, its people, heritage, culture, laws, and literature are hugely influenced and shaped by Islamic *Sharia*. Islamic *Sharia* is, therefore, the foundation that inspires and characterises the country and the Saudi Arabian nation.¹⁰³

3.2. Legislative bodies and procedures in Saudi Arabia

There are several methods to enact, repeal and amend legislation in Saudi Arabia. As I have mentioned in the thesis introduction, the Custodian of the Two Holy Mosques, the King of Saudi Arabia, has enormous power. Accordingly, the first way to enact, repeal or amend any laws in the country is by a Royal Order issued by the King, by the authority of the King as the head of the State.¹⁰⁴ The second way to issue or amend or repeal a law or adopt international or regional treaties or declarations starts with the Saudi Arabian legislative bodies (Council of Ministers and *Shura* Council)¹⁰⁵ proposing a bill or an amendment to a

⁹⁸ A Alghadyan 'The Judiciary in Saudi Arabia' (1998) 13(3) *Arab Law Quarterly* 235-251 p. 235.

⁹⁹ BLG1992 article 7.

¹⁰⁰ LPSC2013 article 1 at http://adlm.moj.gov.sa/ENG/topic_d_d.aspx?ID=61&IDd=337 (accessed 12/09/2015). The same article has been stated in both Law of Criminal Procedure 2013 (LCP2013) at http://adlm.moj.gov.sa/ENG/topic_d_d.aspx?ID=61&IDd=338 (accessed 12/09/2015) and Law of Procedure before the Board of Grievances 2013 (LPBG2013) at http://adlm.moj.gov.sa/ENG/topic_d_d.aspx?ID=61&IDd=339 (accessed 12/09/2015)

¹⁰¹ A Alghadyan 'The Judiciary in Saudi Arabia' p. 235.

¹⁰² J Brand 'Aspects of Saudi Arabian Law and Practice' (1986) 9(1) *B.C. Int'l & Comp. L. Rev* 1-46 p. 13.

¹⁰³ D Long *Culture and Customs of Saudi Arabia* (Greenwood Press 2005) p. 17.

¹⁰⁴ The BLG 1992 articles 44 and 56.

¹⁰⁵ The *Shura* Council members are appointed by the King for four years term (their memberships can be renewed for further term/s). The current *Shura* Council members are 150, 20% of them are women. *Shura* Council Law 1992 (SCL1992) article 3 at <http://www.shura.gov.sa/wps/wcm/connect/ShuraEn/internet/Laws+and+Regulations/> (accessed 12/09/2015).

current Act.¹⁰⁶ If the bill is proposed by the *Shura* Council, it has to be transferred to the Council of Ministers for discussion. Once both Councils agree, the bill will be approved by a Royal Decree, by the King's authority, as he is the Prime Minister.¹⁰⁷ However, if the Council of Ministers proposes a bill or an amendment there is no need to send it to the *Shura* Council for discussion; the bill only requires the King's (as the Prime Minister) Decree to become a valid Act.¹⁰⁸ If the views of both Councils conflict, the bill is returned to the *Shura* Council for further reconsideration or amendment, and then the bill will be sent to the King (as the Prime Minister) to take the final decision regarding the approval of the bill by Royal Decree.¹⁰⁹ After the Act is approved, it must be published in the official gazette and comes into force after the period specified in the Act.¹¹⁰ Throughout this procedure, the bill must be reviewed and read with regard to Islamic *Sharia*.¹¹¹

In addition, the GPSRI, established in 1971,¹¹² is the supreme religious organisation in the Kingdom of Saudi Arabia, headed by the *Mufti* (the Head of Saudi Arabian scholars) and its 21 members, who are all appointed by the King.¹¹³ It is responsible for both religious research and studies and for formulating declarations (*fatawa*).¹¹⁴ Nonetheless, the GPSRI is not a regular part of the Saudi Arabian legislative authorities, but it can participate in the legislative process for enacting a law or amending one that has been approved by the King or adopted by other authorities.¹¹⁵ As a result, it can be said that the GPSRI is always involved in legal and ethical issues¹¹⁶ and, as will be seen, it has played a vital role in setting and regulating many medical legal and ethical principles. Most of them have been directly adopted with no reservation¹¹⁷ by the Saudi Arabian legislative authorities and become a

¹⁰⁶SCL1992 article 12.

¹⁰⁷BLG1992 article 70.

¹⁰⁸The Council of Ministers Law 1992 (CML1992) articles 21 and 22 at <https://www.boe.gov.sa/ViewSystemDetails.aspx?lang=en&SystemID=6&VersionID=11> (accessed 12/09/2015).

¹⁰⁹SCL 1992 article 17.

¹¹⁰CML1992 article 23.

¹¹¹BLG1992 articles 1 and 7.

¹¹²Historically since 1950s the *Mufti* was holding both positions of the head of the Saudi scholars and the judges. The position was separated in the government reform in the beginning of the 1970s. Then in 1994 the position of *Mufti* reassumed, but as separated from the Judiciary. S Shamma 'Law and Lawyers in Saudi Arabia' (1965) 14 *International and Comparative Law Quarterly* 1084-1089, M Hatina *Guardians of Faith in Modern Times: 'Ulama' in the Middle East* (Brill, 2009) p. 211-230 and M Watson. *Prophets and princes: Saudi Arabia from Muhammad to the present* (Wiley 2008) p. 331-395.

¹¹³BLG 1992 article 58.

¹¹⁴*Ibid.* article 45.

¹¹⁵A Allami 'Zakat as Islamic Taxation and its Application in the Contemporary Saudi Legal System' (2009) 5 *JISPI* 8-110 p. 88.

¹¹⁶A Baamier *Sharia Law in Commercial and Banking Arbitration* (MGP book, 2010) p. 28-30.

¹¹⁷For example, the GPSRI declaration no 99 in 1982 stated that '1- It is permissible to transplant a body organ or part of it from a deceased person to a Muslim if it is necessary, and the risks of removing it from the donor are guarded against and the success of transplanting it to the patient is more probable. 2- It is permissible that a living person donates a body organ or part of it to be transplanted into a Muslim who needs this.' at <http://www.alifta.net/Search/ResultDetails.aspx?languagename=en&lang=en&view=result&fatwaNum=&FatwaNumID>

part of Saudi Arabian medical regulations,¹¹⁸ which will be discussed in more detail in Chapter four.

Nonetheless, the legal system of Saudi Arabia is based on legislation and codification that has been formulated in accordance with Islamic *Sharia* principles. There has not been a tradition of case law precedent in terms of establishing, developing or reforming existing Acts or principles.¹¹⁹ However, in 2007 the King enacted the current¹²⁰ LJ2007¹²¹ and LBG2007¹²² which established the Supreme Court¹²³ and the Administrative Supreme Court¹²⁴ in the Board of Grievances.¹²⁵ Based on both Acts, arguably there is now room for applying case law precedent in Saudi Arabia, as the thesis will explain.

Saudi Arabia has a dual judicial system, where there are, firstly, *Sharia* (general) courts for any criminal, or family affairs, civil, commercial and similar disputes and secondly, the Board of Grievances (administrative courts) for any cases that the government or its administrative bodies are part of.¹²⁶ In both *Sharia* courts and Board of Grievances, there are; first degree courts, Courts of Appeal and Supreme Courts.¹²⁷ Additionally there are many Quasi-Judicial committees. The reason for quasi-judicial committees' existence is a historical one as some judges in *Sharia* courts in the 1960s and 1970s balked at applying government regulations in certain areas, holding that Islamic *Sharia* should not be codified in legislation.¹²⁸ Thus, to avoid this contretemps, the government authorised quasi-judicial committees to act as courts when necessary.¹²⁹ Although such reservations by most judges have disappeared, quasi-judicial committees are still in use. One type is significant for this thesis, which is the SMPs, which will be discussed in Chapter four. Some quasi-judicial

=&ID=310&searchScope=17&SearchScopeLevels1=&SearchScopeLevels2=&highLight=1&SearchType=exact&SearchMoe sar=false&bookID=&LeftVal=0&RightVal=0&simple=&SearchCriteria=allwords&PagePath=&siteSection=1&searchkeywo rd=073116032105115032112101114109105115115105098108101032116111032116114097110115112108097110116 032097032098111100121032111114103097110#firstKeyWordFound (accessed 25/06/2015) Which is the main regulation of organs donation in the country. See Saudi Centre for Organ Transplantation at <http://www.scot.gov.sa/> (accessed 11/09/2015).

¹¹⁸ A Adlan 'Informed Consent in Saudi Arabia' p. 896.

¹¹⁹ A Al-Dughaiter 'Authority of Judicial Precedents' (2007) 34 *Al-Adl* 152-172 p. 171-172.

¹²⁰ F Vogel 'Saudi Arabia: Public, Civil, and Individual Sharia in Law and Politics' in R Henfner (ed.) *Sharia Politics Islamic Law and Society in the Modern World* (IUP 2011), 55-93 p. 68.

¹²¹ LJ2007 at http://adlm.moj.gov.sa/ENG/topic_d_d.aspx?ID=36&IDd=39 (accessed 12/09/2015). LJ2007 cancelled LJ1975.

¹²² LBG2007 at http://adlm.moj.gov.sa/ENG/topic_d_d.aspx?ID=36&IDd=40 (accessed 12/09/2015). LBG2007 cancelled LBG1982.

¹²³ LJ2007 article 9.

¹²⁴ LBG 2007 article 8.

¹²⁵ The Board of Grievances is a traditional Islamic name of the courts that deal with public claims against the government or governor actions. Thus, the term Board of Grievances means literally Administrative Courts.

¹²⁶ S Amin *Meddle East Legal System* (Royston Ltd 1985) p. 319.

¹²⁷ LJ2007 article 9 and LBG2007 article 8.

¹²⁸ A Alghadyan 'The Judiciary in Saudi Arabia' p. 246-247.

¹²⁹ *Ibid.* p. 247.

committees also have their appeals heard before quasi-judicial committees, such as the Appellate Custom Committees, that hear appeals by parties in relation to the decision of the first degree Custom Committees.¹³⁰ However, for other of the quasi-judicial committees the judgments may be appealed against at the Administrative Court of Appeal in the Board of Grievances. The SMPs is one of those committees where appeal lies to the Administrative Court of Appeal in the Board of Grievances.¹³¹

In term of the courts' authority to set general principles that can be applied as a law, that authority is given by the relevant Acts to the Supreme Court and the Administrative Supreme Court only. Both Courts are located separately in the capital city, Riyadh.¹³² Each Court is composed of a President¹³³ and 10 other judges, all drawn from the position of the head of a Court of Appeal.¹³⁴ Both Courts have authority as Cassation Courts,¹³⁵ and as the Constitutional Courts.¹³⁶ Furthermore, the general panel of the Supreme Court has a particular duty to '...establish general principles on matters related to the judicial system...'.¹³⁷ The Administrative Supreme Court has the same power to set general principles that are related to administrative laws and cases and these must be followed and applied by lower administrative courts.¹³⁸

This makes it plain that the LJ2007 and LBG2007 have granted both the Supreme Court and the Administrative Supreme Court (in the Board of Grievances) the power to establish legal principles, which must be followed and applied by the lower courts, so in that sense both Courts can participate in establishing law in Saudi Arabia.¹³⁹ Thus, it may suggest that Saudi Arabia's legal system may now apply precedent law as part of its development or establishment of the law. Nonetheless, I would argue that as the country traditionally relies on legislation, the application of the doctrine of precedent might be used in very rare cases, as it is not very common for a case to reach the Supreme Court or the Administrative Supreme Court (in the Board of Grievances). Furthermore, as I have mentioned in the thesis Introduction, a Royal Order established a committee at the beginning of 2015 to translate Islamic *Sharia* principles into legal codes, so this may also suggest that the use of precedent

¹³⁰ Ibid. p. 248.

¹³¹ See Chapter four for further discussion.

¹³² LJ2007 article 10 section 1 and LBG2007 article 10 section 1.

¹³³ LJ2007 article 10 section 2 and LBG2007 article 10 section 2.

¹³⁴ LJ2007 article 10 section 3 and LBG2007 article 10 section 2.

¹³⁵ LPSC2013 article 193 and LPBG2013 article 45.

¹³⁶ LJ2007 article 11 section 2(a) and LBG2007 article 11 section A.

¹³⁷ LJ2007 article 13 section 2(a).

¹³⁸ LBG2007 article 11 section a.

¹³⁹ Note that the Ruler in Islamic *Sharia* is also regarded as the Chief Justice, so the King in Saudi Arabia considered to be the Chief Justice and the Head of the Judiciary System.

is expected to be very limited. Finally, it is rare for medical law cases to reach the Administrative Supreme Court (in the Board of Grievances), thus to rely on this court to develop medical law is not likely to be a practical proposition.

In conclusion, the Chapter so far has presented Islamic *Sharia* principles, sources and the possibilities for Islamic *Sharia* to learn some lessons from English law experiences. Additionally, the Chapter has argued that Muslim scholars have a vital role to set Islamic *Sharia* principles based on their understanding of Islamic *Sharia* main sources. Scholars' views are vital to determine the classification of an act whether it is allowed or not, thus their views become legally binding and a source of Islamic *Sharia* as discussed above in *Ijma* (consensus of opinion) for example. Therefore, Muslim scholars' views and understandings are fundamental (in a way similar to precedent), such as the establishment and the application of the five rulings to determine the permissibility of an action as this thesis will show throughout its discussion in this Chapter and Chapter four.

Additionally, Saudi Arabia's legislative bodies and process and the court system have been addressed. From the foregoing, it is clear that Saudi Arabia is bound by Islamic *Sharia* laws and principles and it has the ultimate authority above all other Saudi Arabian regulations. In comparison with English sources of law, which I discussed in Chapter one, it is clear English law in its formulation and development is traditionally based on common law although legislation has also played an increasing part in establishing and developing it. However, Saudi Arabia's legal system is based on Islamic *Sharia* and legislation, although there is a very limited prospect for the use of the legal doctrine of precedent developed through the Supreme Court or the Administrative Court (in the Board of Grievance). The implications of this are that although English law has developed its legal principles concerning information disclosure through case law, the same approach is unlikely to be useful - at least at the present time - in Saudi Arabia and it is for this reason that a legislative solution to the perceived deficiencies in medical law will be proposed for this country.

This part of the thesis has outlined the relationship between Islamic *Sharia* and the legal system of Saudi Arabia. Islamic *Sharia* therefore has considerable importance in that context as a foundation for all Saudi Arabian law, including that which relates to medical practice. However, before turning to discuss medical law further in Chapter four it is necessary to consider the relationship between Islamic *Sharia* and ethical principles. In what comes next, the thesis will discuss the issue of the principles that form the basis of medical ethics from both an Islamic *Sharia* and more specifically a Saudi Arabian perspective. It will focus on how the approach of Islamic *Sharia* to the principle of respect for autonomy has contributed

to the understanding of medical ethics and the obligations of doctors and patients in Saudi Arabia and, in consequence, how it is relevant to consent to medical treatment and information disclosure. The conclusion of this Chapter will lead to a discussion of Islamic *Sharia* and Saudi Arabia's legal approach to consent and information disclosure in Chapter four.

4. Islamic *Sharia* on medical ethics

It is evident that the influence of Islamic *Sharia* on Saudi Arabian daily life, legal system and laws is considerable. This is because it has been said that what Islamic *Sharia* states both ethically and legally is what Saudi Arabia must apply and acknowledge.¹⁴⁰ Therefore, in the following the thesis will address the issue of the sources of principles relevant to medical ethics in Islamic *Sharia*. It will then go on to examine the principle of respect for personal autonomy in the medical context.

4.1. The foundation of Islamic *Sharia* medical ethics

Islamic *Sharia*, specifically the holy *Quran* and the Messenger's PBUH traditions, plays an essential role in all aspects of all Muslims' lives.¹⁴¹ In terms of Islamic *Sharia* ethics and morals, the holy *Quran* states many general ethical principles such as '[k]indness to parents, forgiveness to those who err, piety, equity, just dealing, compassion, restraint of lust, nobility, modesty etc.'¹⁴² Given the importance of Islamic *Sharia* as the foundation for all ethical conduct it is unsurprising that the same sources of Islamic *Sharia* are applied in both Islamic law and in Islamic medical ethics.¹⁴³ As Padela has stated: 'Islamic medical ethics relates to Islamic law, *Sharia*. The *Sharia* is not only a source of law but assigns moral values to actions in Islam. Hence, any discussion on medical ethics in the light of Islam must refer to it.'¹⁴⁴ (His emphasis). In respect of the application of Islamic *Sharia* to medicine, it has also been stated that medical ethics is 'inseparable from the religion itself, which emphasizes [*sic*] continuities between body and mind, the material and spiritual realms and between ethics and jurisprudence.'¹⁴⁵ Thus, there is unlikely to be any significant difference between Islamic *Sharia* sources and views and Islamic *Sharia* medical ethics.¹⁴⁶ Accordingly, most

¹⁴⁰ BLG1992 articles 1 and 7.

¹⁴¹ A Reinhart 'Islamic Law as Islamic Ethics' p. 189.

¹⁴² L Hussain and S Kazm 'Islam and Contemporary Ethical Challenges' (2010) 1 *Sophia Perennis* 25-51 p. 28.

¹⁴³ M Fakhry *Ethical Theories in Islam* (E.J. Brill 1994) p. 1-8.

¹⁴⁴ A Padela 'Islamic Medical Ethics: A Primer' (2007) 21(3) *Bioethics* 169-178 p. 178.

¹⁴⁵ S Akhmad and L Rosita 'Islamic Bioethics: The Art of Decision Making' p. 9.

¹⁴⁶ A Padela 'Islamic Medical Ethics: A Primer' p. 170.

of the materials that are cited as references for Islamic *Sharia* medical ethics are based on the Islamic *Sharia* primary or secondary sources.¹⁴⁷

Islamic *Sharia* has a sizeable heritage of knowledge and material to assist in considering issues of medical ethics and in resolving new questions which have recently emerged and there are examples of literature in Arabic that illustrate this.¹⁴⁸ An early instance of this in the 9th century was the work of AlRuhawi,¹⁴⁹ *Adab alTabib (Practical Ethics of the Physician)*.¹⁵⁰ The main focus of the book was on doctors' characters: how they should behave themselves and how they should deal with their patients.¹⁵¹ The book also focused on doctors' training and education, and how to treat patients and take care of them in a way that respects patients' dignity and the profession of medicine.¹⁵²

AlTabari¹⁵³ has summarised key principles of medical ethics that have been acknowledged by Muslim society to arise from Islamic *Sharia* as follows:

‘The physician ought to be modest, virtuous, merciful, not slanderous or addicted to liquor and speak no evil of men of repute in the community or be critical of their religious beliefs. He should be honest towards women and should not divulge the secrets of his patients... He should avoid predicting whether the patient will live or die. He should speak well of his acquaintances, colleagues, and clients and not be a money grabber. He should dress in clean clothes, be dignified.... He ought not to lose his temper when his patient keeps asking many questions, but should answer gently and patiently. He should treat the strong and the weak, the rich and the poor, the wise and the illiterate alike, and God will reward him if he offers medical help to the poor... He should be punctual and reliable... avoiding wrangling about his fees with a patient who is very ill, but rather he should be thankful no matter how much he is paid.’¹⁵⁴

However, although there is a significant amount of material relevant to Islamic medical ethics, most of it, as Padela notes, is scattered in Islamic *Sharia* sources which require investigation and the formulation of principles in this specific context.¹⁵⁵

¹⁴⁷ D Donaldson *Studies in Muslim Ethics* (S.P.C.K. 1953) p. ix-xi.

¹⁴⁸ R Veatch *Hippocratic, Religious, and Secular Medical Ethics: The Points of Conflict* (GUP 2013) p.38.

¹⁴⁹ About Al-Ruhawi and his work see S Aksoy 'The Religious Tradition of Ishaq Ali al-Ruhawi: The Author of the First Medical Ethics Book in Islamic Medicine' (2004) 3 *JISHIM* 9-11 and M Al Kawi 'History of Medical Records and Peer Review' (1997) 17(3) *Annals of Saudi Medicine* 227-228.

¹⁵⁰ M Levey 'Medical Ethics of Medieval Islam with Special Reference to Al-Ruhawi's 'Practical Ethics of the Physician'' (1967) 57(3) *Transactions of the American Philosophical Society* 1-100.

¹⁵¹ S Alghzali 'Medical Ethics in Islamic History at a Glance' (2004) 3 *JISHIM* 12-13 p. 12-13.

¹⁵² B Zikria 'Adab Altalib' (1981) 13 *JIMA* 79- 80 p. 79-80.

¹⁵³ F Ghaffari *et al.* 'Abul- Hasan al-Tabari: A Review of his Views and Works' (2014) 17(4) *Archives of Iranian Medicine*, 299-301.

¹⁵⁴ S Hamiarneh 'The Physician and the Health Professions in Medieval Islam' (1971) 47(9) *Bull.N. Y. Acad. Med.* 1088-1110 p. 1105-1106.

¹⁵⁵ A Padela 'Medical Ethics in Religious Traditions: A Study of Judaism, Catholicism, and Islam' p. 112.

4.2. The relationship between Islamic religion, ethic and law

Firstly, as has been argued above and emphasised, Islamic religion, ethics and law are based on the same sources. Therefore, to discuss any religious or ethical or legal matters, the same sources must be used and applied.¹⁵⁶ However, Reinhart has observed in this regard that: ‘Islamic law is more basic to Islamic ethics than is either Islamic theology or philosophy’.¹⁵⁷ This observation by Reinhart can be justified because ‘...moral and legal acts are so intricately related in the *Sharia* to submission to God, by contrast with a far greater autonomy from religion accorded morality and law in Christianity’.¹⁵⁸ Nevertheless, arguably there is a bright and crucial line to distinguish whether the issue is only a religious and ethical matter or is a religious, ethical and *legal* matter.¹⁵⁹ This has an obvious and significant bearing on how conduct which is not in accordance with Islamic *Sharia* is dealt with, and this will include breaches of obligations by doctors. To make that clear, I will illustrate it in the following example:

Islam prohibits lying,¹⁶⁰ so to not always be truthful¹⁶¹ is a religiously and ethically wrong action and whoever lies is committing a sin. Muslims who lie are in disobedience of Allah’s orders, so the liar will be judged for that in the afterlife.¹⁶² However, the question is: by lying, is the Muslim breaching Islamic law? In other words, should he or she be disciplined for all types of lie in this life? The answer commonly is no, except specific instances of lying: for example, that which is committed when a Muslim gives evidence under oath (perjury).¹⁶³ In this situation, the action of lying is not only religiously and ethically wrong, but also obviously legally wrong.¹⁶⁴

Therefore, it can be said that, in order to distinguish if an action might be only religiously and ethically wrong, one needs to look at whether Islamic *Sharia* considers that action to be

¹⁵⁶ G Rice ‘Islamic Ethics and the Implications for Business’ (1999) 18(4) *Journal of Business Ethics* 345-358 p. 346.

¹⁵⁷ A Reinhart ‘Islamic Law as Islamic Ethics.’ p. 186.

¹⁵⁸ F Carney ‘Some aspects of Islamic Ethics’ (1983) 63(2) *The Journal of Religion* 159-174 p. 163.

¹⁵⁹ A Reinhart ‘Islamic Law as Islamic Ethics’ p. 195-196.

¹⁶⁰ The holy *Quran* in translation states ‘...So shun the abomination (worshipping) of idol, and shun lying speech (false statements)’ (CH22: 30).

¹⁶¹ There are three events where lying is permissible (*Halal*), the Messenger PBUH said: ‘It is not lawful to lie except in three cases: Something the man tells his wife to please her, to lie during war, and to lie in order to bring peace between the people.’ M Tirmidhi *Jami at-AtTirmidi* at <http://sunnah.com/tirmidhi/27/45> (accessed 01/12/2014).

¹⁶² Unless he or she asks for forgiveness and makes repentance before dying and that repentance is accepted by Allah. This action of regretting the wrong is between the Muslim and Allah, as no one can tell in this life whether the repentance is accepted or not.

¹⁶³ G Bechor *God in the Courtroom: The Transformation of Courtroom Oath and Perjury Between Islamic and Franco-Egyptian Law (Studies in Islamic Law and Society)* (Brill Academic Pub 2011) p. 378-380.

¹⁶⁴ The Messenger PBUH warned about the seriousness of perjury as He said ‘the biggest of Al-Kabair (the great sins) are (1) to join others as partners in being worshiped with Allah, (2) to murder a human being, (3) to be undutiful to one’s parents (4) and to make a false statement, or said, to give a false witness.’ M AlBukhari *Sahih al-Bukhari* at <http://sunnah.com/bukhari/87/10> (accessed 01/12/2014).

in a breach of Islamic law (as a criminal or civil wrong).¹⁶⁵ So for example, murdering an innocent person is religiously, ethically and legally wrong, because it is not only sinful, but also a crime.¹⁶⁶ Other actions might be only ethically and religiously wrong, such as not returning a greeting to another person in a similar or better way. Such behaviour is ethically and religiously wrong because of the lack of courtesy, but it is not legal wrong as it is not a crime.¹⁶⁷

Secondly, as I have mentioned above, it is important to note that under Islamic *Sharia*, an issue (whether it involves religion, ethics or law) may be classified in five different ways depending on the degree of obligation and value ascribed to adhering to it. It has been argued that,

‘the scale of the values attached by Islamic law to the acts of man comprises five values, whereas other legal systems know only three values: an act may be mandatory in law, prohibited or indifferent. In this last category are lumped together the three Islamic categories of praiseworthy, blameworthy and indifferent’.¹⁶⁸

These five rulings or values (*al-Ahkam al-Khamsah*) concerning the degree or scale of permissibility of an action in Islamic *Sharia*, were introduced to Islamic *Sharia* jurisprudence by Muslim scholars at various times during the history of Islam and scholars have also determined which actions should be classified under each ruling.¹⁶⁹ The five rulings are: *Wajib* (obligatory), *Moharm* (forbidden), *Makroh* (blameworthy), *Mandob* (praiseworthy) and *Mobah* (indifferent).¹⁷⁰

(1) *Wajib* (obligatory) is any duty that Islamic *Sharia* has ordered all Muslims to perform, such as praying five times a day and fasting during the month of *Ramadan*.¹⁷¹ In general, *Wajib* is an act for which there is a reward in the hereafter; however, neglecting or

¹⁶⁵ M Baderin ‘Understanding Islamic Law in Theory and Practice’ (2009) 9(3) *Legal Information Management* 186 -190 p. 186-187.

¹⁶⁶ The holy *Quran* in translation states ‘That is why We decreed for the children of Israel that whosoever kills a human being, except (as punishment) for murder or for spreading corruption in the land, it shall be like killing all humanity; and whosoever saves a life, saves the entire human race. Our apostles brought clear proofs to them; but even after that most of them committed excesses in the land.’ (CH5: 32).

¹⁶⁷ M Baderin ‘Understanding Islamic Law in Theory and Practice’ p. 186.

¹⁶⁸ G Bader ‘Islamic Law: Its Relation to Other Legal Systems’ p. 189.

¹⁶⁹ The start of considering and developing the five rulings can be traced back until the 7th and 8th centuries. K Faruki ‘Al-Ahkam Al-khamsah: The Five Values’ (1966) 5(1) *Islamic Studies* 43-98.

¹⁷⁰ For example, F Carne ‘Some Aspects of Islamic Ethics’ (1983) 63(2) *The Journal of Religion* at 159-174 p. 160, D Brown ‘Islamic Ethics in Comparative Perspective’ (1999) LXXXIX (2) *The Muslim world* 181-192 p. 186-188 and A Daar and A Khitamy ‘Bioethics for Clinicians: 21. Islamic Bioethics’ (2001) 146 (1) *JAMC* 60-63 p. 61.

¹⁷¹ A Reinhart ‘Islamic Law as Islamic Ethics’ p. 195.

abandoning it is a sin and illegal so there can be a punishment in the hereafter and in this life.¹⁷²

(2) *Moharm* (forbidden) is any act that all Muslims have to avoid and must not perform,¹⁷³ such as drinking alcohol and committing theft. In general, as with *Wajib* acts, *Moharm* is an act that is a sin and illegal there can be a punishment in this life and in the hereafter for doing it; and for avoiding it there is a reward in the hereafter.¹⁷⁴

(3) *Makroh* (blameworthy) is any act according to Islamic *Sharia* that all Muslims ought to avoid for piety and virtue, such as drinking or eating while standing.¹⁷⁵ In general, *Makroh* is an act which for there is a reward in the hereafter for avoiding it; however, for doing it there is no sin or punishment in life or hereafter.¹⁷⁶

(4) *Mandob* (praiseworthy) is any act that in Islamic *Sharia* is praiseworthy but not required, such as giving.¹⁷⁷ In general, *Mandob* is an act that for which there is a reward in the hereafter; however, for not doing it there is no sin or punishment in life or hereafter.¹⁷⁸

(5) *Mobah* (indifferent) is any act that in Islamic *Sharia* there is no reward or sin or punishment in life or in the hereafter for, whether doing or avoiding them, such as eating food, buying and selling and so forth.¹⁷⁹

It has been argued that: ‘These five categories represent not only the Islamic understanding of how the upright life is to be lived in the world, but an explicit rejection of the bi-polar view of moral categorization as simply good and bad.’¹⁸⁰ These five rulings will be applied in the discussion of both Islamic *Sharia* medical ethics and laws in this Chapter and in Chapter four. As noted earlier, there are few Islamic *Sharia* sources that specifically consider the matter of respect for patient autonomy in regard to information disclosure as either an ethical or a legal issue. It has also been explained that the five rulings set out above have been used to judge the permissibility of an action in Islamic *Sharia*. This has led me to study the issue of respecting patients’ autonomy in the light of the five rulings that Muslim scholars use to study an issue to determine whether conduct should be considered to be ethically right

¹⁷² I Nyazee *Islamic Jurisprudence: Usul al-Fiqh* p. 53.

¹⁷³ *Ibid.* p. 68.

¹⁷⁴ *Ibid.*

¹⁷⁵ A Reinhart ‘Islamic Law as Islamic Ethics’ p. 195.

¹⁷⁶ K Faruki ‘Al-Ahkam Al-khamsah: The Five Values’ p. 43.

¹⁷⁷ A Reinhart ‘Islamic Law as Islamic Ethics’ p. 195.

¹⁷⁸ I Nyazee *Islamic Jurisprudence: Usul al-Fiqh* p. 65.

¹⁷⁹ A Reinhart ‘Islamic Law as Islamic Ethics’ p. 195.

¹⁸⁰ *Ibid.*

or wrong. The same approach will be applied in Chapter four to classify the legality of issues raised in respect of consent or providing information, for matters that have not been yet addressed by Saudi Arabian law.

However, before turning to the application of these five rulings to the issue of consent to treatment and information disclosure and the application of the principle of respect for autonomy, it is necessary to consider the role of Saudi Commission for Health Specialties (SCHS). The reason for that is because the SCHS is the responsible body in Saudi Arabia for medical professionals' registrations. More importantly for this thesis, the SCHS has authority to issue a medical ethics code for the profession. While it is not itself of course an Islamic *Sharia* source, it is significant (as will be explained) as a source of both ethics and law for medical professionals, and as such it is expected to be in accordance with *Sharia* principles. Therefore, in the following the thesis will briefly present SCHS's role.

4.3. The role of the SCHS

The SCHS was established by Royal Decree in 1993.¹⁸¹ The SCHS 'is responsible for supervising and evaluating training programs, as well as setting controls and standards for the practice of health professions.'¹⁸² In terms of considering medical ethics, the SCHS has the authority to issue ethical guidelines.¹⁸³ A review was undertaken of a previous CEHP in 2011¹⁸⁴ and the current Code was published by the SCHS in 2013.¹⁸⁵ It is important to note that CEHP2013 is legally binding, as LPHP2005 has stated that 'any ethical guidelines issued by the Commission for Health Specialties including the Code of Ethics for Healthcare Practitioners are incumbent upon and applicable to all health practitioners'¹⁸⁶ in the country. Therefore, CEHP2013 is both an ethical and a legal guideline and can be enforced by the law.¹⁸⁷ Because CEHP2013 covers most medical ethics issues, such as patient consent and information disclosure, the discussion in this Chapter and Chapter four will consider CEHP2013 as both an ethical and a legal document.

¹⁸¹ SCHS at <http://www.scfhs.org.sa/en/about/Pages/default.aspx> (accessed 30/11/2014).

¹⁸² The Law of Saudi Commission for Health Specialties 1993 article 2 (Arabic).

¹⁸³ Ibid. article 2 section 11 (Arabic).

¹⁸⁴ The first edition of the CEHP was issued in 1999, then the second edition was issued in 2003. The CEHP2013 was produced by experts in Islamic religion, medical ethics, medical profession and Islamic law as the committee contained doctors, Saudi Muslim scholars and judges. CEHP2013 p. 1.

¹⁸⁵ The press statement (08 December 2013) in regard to 'SCHS Issues the Code of Ethics for Health Practitioners'. The SCHS acting Secretary General Suleiman bin Imran al-Imran, emphasised that 'the Code of Ethics is an important document that the trainee must uphold and abide by throughout medical practice.'
<http://www.scfhs.org.sa/en/Media/News/Pages/news27.aspx> (accessed 05/12/2014).

¹⁸⁶ LPHP 2005 article 5 section 2 the executive regulation (Arabic).

¹⁸⁷ CEHP 2013 p. 9.

In summary, from what has so far been discussed, it can be said that the sources of Islamic *Sharia* ethics and legal principles are the same. Therefore, there may be a very fine line to differentiate between whether the matter is an ethical and religious one only, or it is an ethical, religious and legal matter. The difference is significant however, as this will have consequences for whether an action can be dealt with in the courts as a violation of Islamic *Sharia* law. Of course, as Chapter four will illustrate, legislation makes it clear when some matters can become before the courts, but legislation does not cover all matters for which there may be legal actions. Further, the thesis has argued that any ethical, religious and legal matter should be considered under the five rulings for determining its classification. Finally, it should be remembered that CEHP2013 is both an ethical and a legal code.

In the following, the thesis will move on to discuss the issue of Islamic *Sharia*'s Saudi Arabian medical ethics' acknowledgment of the principle of respect for autonomy in regard to competent adult patients' consent and the issue of information disclosure. It should be remembered that, as there are not many sources that deal with the issue of information disclosure and autonomy, the discussion proceeds on the limited material that is available.

5. The principle of respect for autonomy based on Islamic *Sharia* its use in Saudi Arabian medical ethics

Although there are few sources directly dealing with information disclosure and consent to treatment, Islamic *Sharia* can be said to manage many aspects of health and medicine by establishing a number of principles and rules regarding how to deal with fundamental ethical and legal matters.¹⁸⁸ According to Islamic *Sharia* teaching, human beings are born free with full rights and freedoms that enable them to act without restriction and which protect them from any offences or reckless actions. Caliph Omar Ibn Alkhattab¹⁸⁹ thirteen centuries ago made a notable declaration of human rights when he asked, 'when did you enslave people who have been born free?'¹⁹⁰ Islamic *Sharia* recognises the basic rights of all humans, not just those of Muslims. This recognition of human rights based on Islamic *Sharia* has been acknowledged by the Saudi Arabian BLG1992 which declares that: 'The State shall protect human rights in accordance with the *Sharia*'.¹⁹¹

¹⁸⁸K Baddarni 'Ethical Dilemmas and the Dying Muslim Patient' (2010) 11 *Asian Pacific J Cancer Prev* 107-112 p. 107.

¹⁸⁹ The second Muslim Caliph, born in 586, became Caliph in 633 and was assassinated in 644.

'Khalifa Umar bin al-Khattab' at <http://www.alim.org/library/biography/khalifa/KUM> (accessed 11/09/2015).

¹⁹⁰ The story behind this quotation happened in Egypt. A Coptic citizen won a horse race against the son of the Islamic governor of Egypt, but was whipped by his opponent. The Copt went to Omar in AlMadinah AlMunawwarah (the capital of the Islamic nation at that time) to sue the governor's son. Caliph Omar took no notice of the culprit's religion or of his father's position, but punished him, making the famous declaration. I Alharbi *Democracy in Islamic and International Law* (Author House 2011) p. 248.

¹⁹¹BLG1992 article 26.

It has been argued that the term ‘autonomy’ or the principle of respect for autonomy, has its foundations and roots in such Islamic *Sharia* sources.¹⁹² However, a question for this thesis is whether Islamic *Sharia* acknowledges the principle of respect for autonomy in the same way as it is understood in the Western tradition of ethics. A further question arises: what might Islamic *Sharia* principles mean in the context of providing medical treatment, in particular obtaining consent and information disclosure?

The idea of respect for autonomy in Islamic *Sharia* has appeared in sources where autonomy has been discussed in the light of other basic human rights. In the view of Islamic *Sharia*, autonomy can be established by the holy *Quran* as it states in translation that: ‘And indeed We [Allah] have honoured the children of Adam...’¹⁹³ Based on this holy verse it has been argued that respect for the individual is a main aspect of human dignity, and respect for an individual implies respect for the individual’s rights, decisions, choices and wishes.¹⁹⁴ Therefore, it has been assumed that individual autonomy has been accepted and exists under Islamic *Sharia*.¹⁹⁵ This gives each person the right to make free, autonomous decisions and choices based on Islamic *Sharia* traditions and therefore generally this should be respected.¹⁹⁶ Therefore, it has been said that ‘there is considerable room for personal autonomy in Islam...The sense of personal liberty that this allowed contributed to the strength of the social system’.¹⁹⁷

However, the meaning of patient autonomy under Islamic *Sharia* needs closer examination to consider whether it differs in any respect from the interpretations of patient autonomy under the Western tradition. In particular, Islamic *Sharia* places great emphasis on the idea of personal responsibilities and rights.¹⁹⁸ However, Islamic *Sharia* does not allow a person to perform actions or make choices solely according to their own wishes and desires.¹⁹⁹

¹⁹² M AlBar and H Pasha *Contemporary Bioethics Islamic Perspective* (Springer International Publishing 2015), D Atighetch, *Islamic Bioethics: Problems and Perspectives*, Y Mustafa ‘Islam and the Four Principles of Medical Ethics’ (2014) 40 *J Med Ethics* 479–483, H Pasha and M AlBar ‘Western and Islamic Bioethics: How Close is the Gap?’ (2013) 3(1) *Avicenna Journal of Medicine* 8-14, M Rathor *et al.* ‘The Principle of Autonomy as Related to Personal Decision Making Concerning Health and Research from an Islamic Viewpoint’ (2011) 43 *JIMA* 27-34, E Anna *et al.* ‘Communicating with Muslim Parents: ‘the Four Principles’ are not as Culturally Neutral as Suggested’ (2009) 168 *Eur J Pediatr* 1383-1387, S Aksoy and A Elmali ‘The Core Concepts of the ‘four Principles’ of Bioethics as Founded in Islamic Tradition’ (2002) 21 *Med Law* 211-224, S Aksoy and A Tenik ‘The ‘four Principles of Bioethics’ as Found in 13th Century Muslim Scholar Mawlana’s Teachings’ (2002) 3 *BMC Med Ethics* 1-7, A Bommel ‘Medical Ethics from the Muslim Perspective’ (1999) 74 *Acta Neurochirurgica Supplement*. 17-27, G Serour ‘Islam and the Four Principle’ in R Gillon (ed.) *Principles of Health Care Ethics*. (John Wiley and Sons 1994) 75-91 and K Hasan ‘Islam and the four Principle: a Pakistani View’ in R Gillon (ed.) *Principles of Health Care Ethics*. (John Wiley and Sons 1994) 93-103.

¹⁹³ The holy *Quran* in translation (CH17:70).

¹⁹⁴ H Fadel ‘Ethics of Clinical Research: An Islamic Perspective’ (2010) 42 *JIMA* 59-69 p. 61.

¹⁹⁵ D Atighetch *Islamic Bioethics: Problems and Perspectives*. p. 21-22.

¹⁹⁶ A Gatrad and A Sheikh ‘Medical Ethics and Islam: Principles and Practice’ p.73.

¹⁹⁷ K Hasan ‘Islam and the Four Principle: a Pakistani View’ p. 96.

¹⁹⁸ Y Mustafa ‘Islam and the Four Principles of Medical Ethics’ p. 482.

¹⁹⁹ *Ibid.*

There are limits on a person's freedom and choices, as these must be made in line with certain rules and these rules are essentially based on Islamic *Sharia* sources.²⁰⁰ Bommel has stated that: 'For a Muslim patient, absolute autonomy is very rare, there will be a feeling of responsibility towards God, and he or she lives in social coherence...'.²⁰¹ Hence, it can be argued that a personal choice can be respected and accepted but only if it is in accordance with Islamic *Sharia* rules.²⁰² AlBar and Pasha have argued that the Western interpretation of autonomy should not be universally accepted and applied in the same way, as it has been introduced for example by Beauchamp and Childress,²⁰³ as there are likely different conceptions and understandings of autonomy in other countries' cultures, religions and social backgrounds.²⁰⁴

The main focus of the thesis is regarding the issue of information disclosure, but it is worth mentioning some general Islamic *Sharia* reservations on the application of the principle of respect for autonomy. Based on Islamic *Sharia* teaching, Muslims are entrusted with their bodies, health, lives, wealth and so forth by Allah; therefore, the Muslim can only act in the ways set out by the will of Allah and in the teachings of his Messenger's PBUH about them.²⁰⁵ For example, Islamic *Sharia* values health and the protection of it. It considers health as a great blessing, which can be seen when the Messenger PBUH said: 'There are two blessings which many people lose: (They are) health and free time for doing good.'²⁰⁶ Consequently, the Muslim is not allowed to hurt or cause harm to him/herself or others, and doing so is against Islamic *Sharia* teaching.²⁰⁷ Similarly, based on Islamic *Sharia* healthcare providers have a duty to encourage and educate patients to avoid dangerous behaviours and habits that would affect their health, as the healthcare provider is responsible ethically and religiously for providing information as well as for providing medical care for their patients.²⁰⁸

Similar to some arguments under English law,²⁰⁹ another limitation on Islamic *Sharia*'s respect for autonomy concerns whether Muslims are allowed to end their own lives. They are not permitted to do so because life is given to the person by Allah, so a Muslim is not

²⁰⁰ S Aksoy and A Tenik 'The 'four Principles of Bioethics' as Found in 13th Century Muslim Scholar Mawlana's Teachings.' p. 3.

²⁰¹ A Bommel 'Medical Ethics from the Muslim Perspective' p. 19.

²⁰² H Pasha and M AlBar 'Western and Islamic Bioethics: How Close is the Gap?' p. 10.

²⁰³ T Beauchamp and J Childress *Principles of Biomedical Ethics*.

²⁰⁴ H Pasha and M AlBar 'Western and Islamic Bioethics: How Close is the Gap?' p. 10.

²⁰⁵ D Atighet *Islamic Bioethics: Problems and Perspectives* p. 35.

²⁰⁶ M AlBukhari *Sahih Al-Bukhari* at <http://sunnah.com/bukhari/81/1> (accessed 28/03/2015).

²⁰⁷ S Aksoy and A Elmali 'The Core Concepts of the 'four Principles' of Bioethics as Founded in Islamic Tradition' p. 217.

²⁰⁸ H Pasha and M AlBar 'Western and Islamic Bioethics: How Close is the Gap?' p. 10.

²⁰⁹ See Chapter one for further discussion.

allowed to kill him/herself.²¹⁰ Preserving life is fundamental in Islamic *Sharia*, so where the Muslim's action is to take his or her life, or even to harm him/herself or critically damage his or her health, his or her choices should be disregarded.²¹¹ In consequence, doctors have no right to terminate a patient's life or assist the patient to die based on respect for his or her choices, and they should prevent patients from ending their own lives.²¹² Doctors and patients should consider that there is a vast and infinite reward from Allah for those who remain patient in suffering. The holy *Quran* contains a passage that in translation states that 'only those who are patient (forbearing) shall receive their rewards in full, without reckoning.'²¹³ However, that does not mean patients should not seek treatment; they should seek treatment as part of their obligation to preserve life and health, although this should be undertaken in the belief that Allah is the ultimate healer of illness,²¹⁴ as the holy *Quran* in translation states that 'and when I am ill, it is He [Allah] who cures me.'²¹⁵ I will further consider this issue of seeking treatment below.

It can be concluded that Islamic *Sharia* has acknowledged the notion of respect for the principle of patient autonomy, but it is different in some ways from that of the Western traditions discussed in Chapter one and which form the basis for current medical ethics in the UK.²¹⁶ Thus, in Muslim countries like Saudi Arabia, respect for patients' autonomy in terms of their wishes and choices must be in accordance with Islamic *Sharia* and it is not primarily a matter of respecting patients' wishes in so far as they do not infringe the rights of others.²¹⁷

As I have discussed in Chapter one, the foundation of the principle of respect for autonomy in Western medical ethics has been influenced strongly by the writings of Kant and Mill. The notion of consequentialism/utilitarianism to judge whether an act is ethically right or

²¹⁰ The holy *Quran* in translation states: 'Say, Indeed, my prayer, my rites of sacrifice, my living and my dying are for Allah, Lord of the worlds. (162) 'Say: "Shall I search for another lord apart from God when He is the only Lord of all and everything?" Each soul earns (what it earns) for itself, and no man shall bear another's burden. You have to go back to your Lord in the end when He will tell you about the things you disputed. (163).' (CH6:162-163).

²¹¹ E Anna *et al.* 'Communicating with Muslim Parents: 'the Four Principles' are not as Culturally Neutral as Suggested' p. 1385.

²¹² CEHP2013 chapter 14 (11) p. 49 stated that 'It is strictly prohibited for any member of the healthcare team to help a patient take his/her own life by being given high doses of any drug, or teach the patient how to administer it, which is known as physician-assisted suicide, or to participate in euthanasia, through injecting a lethal drug or otherwise, regardless of the pain and suffering of the patient.'

²¹³ The holy *Quran* in translation (CH30:10).

²¹⁴ D Atighetch, *Islamic Bioethics: Problems and Perspectives*. p. 33 and M Rahman 'Therapeutic Interventions: An Islamic Perspective' (2008) 40 *JIMA* 60-68 p. 63.

²¹⁵ The holy *Quran* in translation (CH26:80).

²¹⁶ K Hedayat and R Pirzadeh 'Issues in Islamic Biomedical Ethics: A Primer for the Paediatrician' (2001) 108 *Pediatrics* 965-971 p. 965 -966.

²¹⁷ A Clarfield *et al.* 'Ethical Issues in End-of-life Geriatric Care: The Approach of Three Monotheistic Religions – Judaism, Catholicism and Islam' (2003) 51 *JAGS* 1149-1154 p. 1152.

wrong is based on the outcome of it irrespective of the act itself, which has been developed based on Mill's view. By contrast, deontology has been based on Kant's view that the decision as to the ethical rightness or wrongfulness of an action is based on the action itself, regardless of the circumstances or the consequences. It was concluded that there has been no universal agreement on which of these two approaches is correct, but that both have been regarded as supporting the principle of respect for autonomy.

Bearing in mind the concept of the five rulings, I would argue that the Islamic *Sharia* view on judging whether an action is ethically right or wrong seems to combine aspects of both consequentialism/utilitarianism and deontology. As AlBar and Pasha have argued that: 'In Islamic teachings, though the intention is of paramount importance, the means to fulfil such an intention bear the same value. However, Islamic teachings look to the consequences and if we can predict an evil or bad result then that action should not be taken.'²¹⁸ In fact, the importance of the good intention can be understood from the Messenger PBUH saying that: '(The value of) an action depends on the intention behind it...'²¹⁹ It can be said that, this Messenger PBUH statement is comparable to the approach of consequentialism/utilitarianism as the importance is placed on the intention (outcome) regardless of the action itself. Despite this, Islamic *Sharia* does not state that this is the only approach, and this saying by the Messenger PBUH must be read and understood in the light of the rules that have been stated by the holy *Quran* and the Messenger PBUH. For example, some actions are wrong in themselves, such as stealing, so though the intention of the person to steal is for helping others (a good outcome), it does not justify the action. Thus, the Messenger PBUH in another saying has stated that:

'The lawful is clear and the unlawful is clear, and between that are matters that are doubtful (not clear); many of the people do not know whether it is lawful or unlawful. So whoever leaves it to protect his religion and his honour, then he will be safe, and whoever falls into something from them, then he soon will have fallen into the unlawful...'²²⁰

This suggests that like deontology, there are good and bad actions which are universal and a person can judge their ethical rightness or wrongfulness, and by doing so he/she can make his/her decision.

As the Messenger PBUH has said: 'Do not let yourselves be yes-men, saying: If the people are good then we will be good, and if they are wrong then we will be wrong. Rather, make

²¹⁸M AlBar and H Pasha *Contemporary Bioethics Islamic Perspective* p. 116.

²¹⁹M AlHajji *Sahih Muslim* at <http://sunnah.com/muslim/33/222> (accessed 15/07/2015).

²²⁰M AlTirmidhi *Jami at-Tirmidhi* at <http://sunnah.com/tirmidhi/14/1> (accessed 15/07/2015).

up your own minds, if the people are good then you are good, and if they are evil, then do not behave unjustly.²²¹ Thus, a Muslim, beside having good intentions, should only and independently do what is good and avoid what is bad and not justify doing good or bad by what others do. In other words, the Muslim with good intention should follow Islamic *Sharia* rules in doing good and avoiding bad, regardless of other people's behaviour.

Based on that, I would argue that showing respect for patients' autonomy can be regarded as 'good' as that would make them more independent in making their decisions based on Islamic *Sharia* principles. Thus, it can be said this 'good' combines the views of both utilitarian (intention) and Kantian (universal law).

A recognition of the principle of respect for autonomy in the context of Islamic *Sharia* traditions would require doctors to acknowledge patients' autonomy and provide them with information in order for the patient to freely make an informed decision. Thus, respect for patient autonomy would not justify doctors' suggesting that they should act in accordance with good intentions and therefore choose to provide or withhold information. As I have stated above, it is not only a good intention that justifies the action, but also the action itself must be good. Thus, the respect for autonomy would require doctors in addition to their good intentions to inform patients, and this is regardless of whether other doctors would disclose the information or not. In other words, doctors should fulfil their good intention by providing the patient with sufficient information that s/he requires. Nonetheless, it should be considered that good intentions would require good action; thus if the information would cause the patient serious harm, the doctors' good intention on that basis can justify their actions to withhold distressing information, as I will further discuss below.

As I have stated above my proposed ethical standard is to place a duty on doctors to disclose sufficient and understandable information to enable a competent adult patient to be self-determining and to respect his/her autonomy. This proposed standard will be examined further in this Chapter and Chapter four to demonstrate to what extent it can be achieved under Islamic *Sharia* and Saudi Arabian medical law, and whether that would support the argument that Saudi Arabia should adopt the prudent patient standard of care.

A decision that is not in line with Islamic *Sharia*, because it will cause harm to the person him/herself or to others or it is against other Islamic *Sharia* principles, need not be respected. In order to discuss the principle of respect for autonomy in more depth from the Islamic

²²¹ *Ibid* at <http://sunnah.com/tirmidhi/27/113>(accessed 15/07/2015).

Sharia perspective, the discussion will now be divided into two topics: first, patient consent and respect for autonomy and, second, information disclosure and respect for autonomy.

5.1. Patient consent and respect for autonomy

Consideration of patients' autonomy can be understood based on the views of Islamic *Sharia* (and consequently Saudi Arabian legislation) on the purpose of medicine. Medical treatment in general, from the Islamic *Sharia* perspective, should work in a way that preserves and promotes a patient's health and life by using the available treatments and medical procedures.²²²

As was explained previously in describing Islamic *Sharia* sources, where there is an issue that has no direct reference in the two main *Sharia* sources, Muslim scholars should consider that issue and pronounce their view on it. The notion of respect for the autonomy of patients should be treated in the same way, so it should rely on Muslim scholars' understanding of the matter in the light of Islamic *Sharia* sources.²²³ It must also be remembered that where a new matter is considered there may be more than one view taken, based on the Muslim scholars' understanding, analysis and consideration,²²⁴ unless the majority make an *Ijma* (consensus of opinion) on that matter. A question that emerges here is what doctors and patients in Saudi Arabia should do if there is more than one view on one matter. In other words, can doctors or patients follow whichever scholar's view they believe is correct?

In this regard, where a matter is unclear, then the GPRSI's customary practice would be followed, as this has both ethical and legal status. In the case of continued dispute, the matter would be referred to the GPRSI to either seek the view of the *Mufti* (head of Saudi scholars) or the GPRSI counsel for the Islamic *Sharia* on the issue, which is noted throughout this Chapter and Chapter four.

This may include matters of both ethics and law. It is very rare for law courts (SMPs) to be involved in developing the law in such disputes, as the court is only involved after the patient brings a claim; for example, if damage occurs as a result of an operation and as discussed, there is not a tradition of using precedent in Saudi Arabia. Thus, the GPRSI plays a vital role in setting ethical and legal medical principles and solving ethical and legal disputes that happen before treating the patient. The reason why the GPSRI is involved in such cases will be further explored in Chapter four, but, in brief, historically, the Saudi *Mufti* was the head of judges in the country until the beginning of the 1970s which may justify its roles in

²²² S Akhmad and L Rosita 'Islamic Bioethics: The Art of Decision Making' p. 9.

²²³ See the discussion of Islamic *Sharia* sources above.

²²⁴ A Padela 'Medical Ethics in Religious Traditions: A Study of Judaism, Catholicism, and Islam' p. 114.

addressing issues of ethical and legal concern. This shows an opposite stance from English law, where the standard of consent and information disclosure is decided by law courts and through the doctrine of legal precedent, although professional guidance is also available to doctors.

Unless it is an emergency, legal disputes, such as a patient's refusal of recommended treatment, would be heard by the courts of law in the UK, and it is here that the issue would be decided which would give guidance in future cases.

Additionally, as it was noted earlier, the SCHS issued CEHP2013, which is considered both ethically and legally binding. The review that led to this CEHP2013 was undertaken by some senior Saudi Arabian scholars and judges and therefore may be taken as representing an ethical and legal stance based on Islamic *Sharia*. When the Saudi Arabian government has adopted a GPSRI declaration or other document, whatever the authority of it (*Ijma* or a single *fatwa*), it becomes legally binding and should be applied. Therefore, as CEHP2013 has been issued by a Minister, it is an ethically and legally binding document which must be followed and applied by doctors, hospitals and SMPs in Saudi Arabia. It is therefore useful to refer to CEHP2013 in order to illustrate the medical ethical principles that are applied in Saudi Arabian medical sectors and SMPs. These are also legal principles, but it is the ethical issues that are being focused on here.

The CEHP2013 is the leading guidance on medical ethical issues which is specifically addressed to medical practitioners and it has included a broad statement recognising the importance of patient consent and respect for autonomy, as it has declared that the person's body and soul must be protected. No one has the authority to deal with a person's body unless permission has been granted by the person him/herself.²²⁵

AlBar and Pasha have argued that the concept of autonomy based on the Western understanding should not be considered as a universal principle, as there might be different interpretations based, for example, on culture and background. Thus the Western interpretation of the principle of respect for autonomy may not easily be transplanted and adopted by other countries in the same way.²²⁶ Thus, some characteristics of the concept of autonomy can be interpreted and adjusted by the other adopting systems and can be then modified in a way that suits the recipient system.

²²⁵ CEHP 2013 chapter 2 (C) p. 17.

²²⁶ H Pasha and M AlBar 'Western and Islamic Bioethics: How Close is the Gap?' p. 10.

Thus, the interpretation by Islamic *Sharia* and Saudi Arabian law to some extent will be different from the Western understanding and interpretation. Nonetheless, each legal system shares the underpinning values of respect for autonomy, even if their translation into practice may differ in some ways. However, while it is clear that the concept of individual autonomy is recognised in Saudi Arabian medical ethics and this is based on Islamic *Sharia*, this still remains to be examined in the light of the five rulings mentioned above.²²⁷ These concerns when conduct is considered to be: (1) *Wajib* (obligatory), (2) *Moharm* (forbidden), (3) *Makroh* (blameworthy), (4) *Mandob* (praiseworthy) and (5) *Mobah* (indifferent). Statements contained in CEHP2013 will be used to evaluate the way in which conduct concerning consent to medical treatment should be classified according to these five rulings. It should be noticed that the use and classification of these five rulings in this thesis is firstly to demonstrate the patient's duty or obligation to seek treatment, and secondly to note that this may sometimes include the classification of the treatment itself and whether it is deemed to be necessary. In addition, declarations by the GPSRI and IIFA will also be used to examine this issue since, as discussed previously, these institutions are considered to be principal sources of *Ijma* (consensus of the majority of qualified Muslim scholars regarding new legal, ethical, and other issues) in Saudi Arabia.

The following discussion will be divided into two main headings concerning respect for autonomy: first, where respect for a patient's autonomy is limited, and, second, where there is complete respect for patient autonomy. Under these two headings, there are three main issues to be considered: A. The five rulings, B. The justification of the view taken in respect of the five rulings and C. The religious and ethical consequences. The consequences of conduct being in breach of the rulings that have a legal sanction will be discussed in more detail in Chapter four but for the moment it is sufficient to bear in mind that where a legal principle has not been set out in Saudi Arabian legislation, existing Islamic *Sharia* principles must be followed.

1) Respect for a patient's autonomy is limited

A. The first two rulings

(i) The treatment is *Wajib* (obligatory) for patients to seek if it is vital to preserve the patient's life, or to stop health deterioration which may lead to death or damage to an organ or to prevent the spread of infectious diseases.²²⁸ In such cases (which are not an emergency),²²⁹

²²⁷ A Sachedina *Islamic Biomedical Ethics* (OUP, 2009) p. 35.

²²⁸ IIFA declaration no 10 (1) meeting 19 in 2009 (Arabic).

²²⁹ CEHP 2013 in chapter 14 (5) p. 47 defined an emergency as '... a condition resulting from an injury or disease that could threaten a patient's life, one of his/her limbs, or internal/external organs.' The CEHP2013 urges doctors to 'start

as a general rule a competent adult patient who is conscious and has the ability to understand the information given about his condition and treatment should give his consent and his refusal of consent 'can' be overruled.²³⁰ However, there are some situations where treatment can be refused and need not be provided (as will be explained in B and C below)

(ii) The treatment is *Mohram* (forbidden) for patients to seek if the treatment is prohibited by Islamic *Sharia*. This includes causing harm or damage or death to the person him/herself or others. For example, the patient consenting to removal of an organ for no medical reason.²³¹ Another example is the patient consenting to euthanasia, as this is also prohibited as noted above. Therefore, in those cases or others similar to them, the patient's consent must be ignored and doctors must not respect a patient's autonomous decision to consent to such treatment.²³²

B. The Islamic *Sharia* justification for limiting patient autonomy

The patient's right to make an autonomous decision is limited where treatment is considered as obligatory to seek or forbidden, as the human body and life are regarded as sacred and to be protected.²³³ This is based on Islamic *Sharia* because 'life is sacred: every moment of life has great value, even if it is of poor quality. The saving of life is a duty, and the unwarranted taking of life a grave sin.'²³⁴ This view has its grounds in the holy *Quran*, which states in translation that 'whosoever saves the life of one, it shall be as if he saved the life of all humankind.'²³⁵ Based on this holy article, in the medical field patients are expected in general to preserve their lives, promote their health and not harm themselves because these duties are absolute.²³⁶ Thus, when a patient's life is in danger or a treatment is required, he should consent to treatment, as refusing treatment which would lead to death or worsening health is forbidden under Islamic *Sharia*. The holy *Quran* has given the instruction: '...and do not cast yourselves into ruin with your own hands'.²³⁷

Similarly, although an individual's autonomy is respected under Islamic *Sharia*, this does not extend to allowing a person to put him/herself in danger by consenting to treatment that

medical intervention without waiting for permission of the patient or guardian; this is conditional that the patient may be exposed to imminent death or severe harm, or there is high probability for such harm.'

²³⁰ IIFA declaration no 10 (2) meeting 19 in 2009 (Arabic).

²³¹ M Qayyim alJawziyyah *Tuhfatul Mawdud bi Ahkam al-Mawlud: (A Gift to the Loved One Regarding the Rulings of the Newborn)* (Almaktabh Alasriah 2009) p. 149 (Arabic).

²³² M AlShanqeeti *Ahkam Algerhah Altibeh w Alather Almotrtbh Aliha. (Rulings of Medical Surgeries and Their Consequences)*. (3rd ed Alshabah publisher 2004) p. 168 (Arabic).

²³³ D Atighetch *Islamic Bioethics: Problems and Perspectives*. p. 33.

²³⁴ A Daar and A AlKhitamy 'Bioethics for Clinicians: 21. Islamic Bioethics' (2001) 164(1) *J AMC* 60-63 p. 61.

²³⁵ The holy *Quran* (CH32:113).

²³⁶ A Daar and A AlKhitamy 'Bioethics for Clinicians: 21. Islamic Bioethics' p. 61.

²³⁷ The holy *Quran* in translation (CH2:195).

is not permitted by Islamic *Sharia* or may lead to death, as life is ‘a gift from Allah and is to be cherished and protected at all times.’²³⁸ Based on this, to keep healthy and to prevent harm are basic principles in Islamic healthcare for both the individual and the community.²³⁹

Muslim doctors have religious and ethical duties toward patients, derived from a religious basis.²⁴⁰ The holy *Quran* in translation states that ‘the believers are nothing else than brothers (in Islamic religion)’.²⁴¹ A doctor should behave and act in a way that respects and benefits his brother or sister patients and provide them with treatment they need.²⁴² In considering respect for patient autonomy, this is also an important principle of Islamic *Sharia*. Presumably the CEHP2013, the GPRSI and IIFA all accept this and take this as their starting point when considering consent to and refusal of medical treatment.

C. The religious and ethical consequences of failing to comply with these rulings

i. *Wajib* treatment

For both doctors’ and patients’ ethical and religious duties to be complied with, it seems that there are two distinguishable views:

1. The case of curable illness

As I have stated above that for the *Wajib* treatment, a patient ‘should’, but does not ‘have to’ seek it in all cases. It can be argued that, as long as not seeking the treatment would not lead to severe harm or death, there might be no ethical or religious duty on patients to consent to treatment for curable or treatable illnesses and that doctors can respect patients’ refusal of consent.²⁴³

CEHP2013 has straightforwardly dealt with the case of incurable illness, as I will discuss in a moment, but it has not clearly dealt with the case of curable illness. CEHP2013 has set a general rule for the issue of ‘[d]ealing with patients who refuse a medical procedure.’²⁴⁴ However, CEHP2013 has stated specific rules to deal with the matter of incurable illness.²⁴⁵

²³⁸ M Yousuf and A Fauzi ‘Euthanasia and Physician-Assisted Suicide: A Review from Islamic Point of View’ (2012) 11(1) *IMJM* 63-68 p. 64-65.

²³⁹ H Pasha and M AlBar ‘Western and Islamic Bioethics: How Close is the Gap?’ p. 10.

²⁴⁰ B Zikria ‘Adab Altāibib’ p. 79-80.

²⁴¹ The holy *Quran* in translation (CH 49:10).

²⁴² Q AlMubarak, *Altadwi wa Almsolih Altbieh fa Alshraiah Aleslamih (Treatment and Medical Liability in Islamic Sharia)*, (1st ed Alfarabi publisher 1991) p. 37-40 (Arabic).

²⁴³ K Baddarni ‘Ethical Dilemmas and the Dying Muslim Patient’ p. 108.

²⁴⁴ CEHP2013 chapter 2(G) p. 21.

²⁴⁵ *Ibid.* chapter 15(A) p. 50.

By excluding this from the general rule, thus I would argue that the following rules are dealing with curable illness only.

I would argue in such cases CEHP2013 has recognised the general right of a competent adult patient to refuse medical treatment, and directed doctors to take the following steps: first, doctors must ensure that the patient is ‘...aware of the consequences of his/her decision to refuse the medical procedure’.²⁴⁶ Second, doctors must explain in simple and understandable words ‘... the importance of the medical procedure, and the consequences of not having the procedure honestly and without exaggeration.’²⁴⁷ Third, the doctor has a duty to ‘...do whatever is possible to convince the patient as well as make him/her aware of the alternatives, and then to make the appropriate decisions after that’.²⁴⁸ Finally, the patient’s consent or refusal of consent must be documented in writing.²⁴⁹ Nevertheless, in Saudi Arabia Islamic *Sharia* has supremacy in the country so the interpretation of an Act or code must be in the content of Islamic *Sharia*. Thus, it seems likely that, if refusing necessary treatment for curable illness that may lead to severe harm or death, the case would be different.

The GPSRI has considered the matter of refusing necessary treatment of a curable illness based on questions from the Head of both the Health Department in the Ministry of the National Guard and King Saud University for Health Sciences.²⁵⁰ The first question was: where a competent adult patient who is conscious and has the capacity to understand the information, is suffering from bowel perforation and he has been clearly informed about the seriousness of the case, the medical procedures of the surgery and the consequence (death) of refusing the operation, as it is the only option to treat his condition, should doctors respect his right to refuse the operation or should they treat him irrespective of his refusal? The GPSRI has ruled that ‘if the case was as had been described, the operation has to be performed without a patient’s consent, as it would preserve the patient’s life and prevent health deterioration.’²⁵¹

The second question was about an adult competent pregnant woman in the final stage of her pregnancy who is conscious and has the capacity to understand the information. The doctors’ view was she could not give birth naturally and she was medically required to have a

²⁴⁶ *Ibid.* chapter 2(G)1 p. 21.

²⁴⁷ *Ibid.* chapter 2(G)3 p. 21.

²⁴⁸ *Ibid.* chapter 2(G)4 p. 21.

²⁴⁹ *Ibid.* chapter 2(G)5 p. 21.

²⁵⁰ The issues were handed to GPSRI in 2009 (Arabic).

²⁵¹ GPSRI declaration no 25319 request 2 in 2009 (Arabic).

Caesarean section. The woman refused to have the operation, even though she had been informed about the result of her refusal being that the unborn child would die. The GPSRI has declared that ‘if the Caesarean section would not cause the mother high risks or death, her refusal must be ignored and the Caesarean section has to be conducted to save the unborn child’s life, otherwise her refusal must be respected.’²⁵²

Thus, it can be said that while there might be no ethical wrong for patients to refuse treatment for curable illness and doctors should respect patients’ wishes as long as those wishes do not lead to severe harm or death, if these conditions are not met both doctors and patients would be ethically and religiously wrong not to proceed with the treatment.

2. The case of incurable illness

The view here is different from above; it seems that in the case of incurable illness patients might be free ethically to refuse treatment that they would otherwise be expected to seek.²⁵³ Doctors should not ethically and religiously have a duty to attempt to provide treatment that will be ineffective. The difference is that in the previous category there is strong medical evidence which states that the illness can be treated, whereas in this category there is strong medical evidence that indicates that the illness cannot be cured, such as terminal cancer, although the pain and suffering may be reduced and controlled for a period of time.²⁵⁴

CEHP2013 has considered the issue: ‘[d]oes the patient have the right to refuse treatment in incurable conditions?’²⁵⁵ Firstly, CEHP2013 has recognised in the case of incurable illness that ‘the general rule is that the patient has the right to make any decision whether to accept or refuse therapeutic interventions proposed by a doctor, in part or in whole.’²⁵⁶ He or she must have ‘... fully understood the medical information related to his/her condition, and the consequences of such refusal, benefits of the treatment, and risks associated with his/her decisions (to refuse the treatment).’²⁵⁷ Thus, ‘...the doctor does not have the right to force the patient to accept treatment’.²⁵⁸ Nevertheless, CEHP2013 has placed different ethical duties on doctors in some cases of patient refusal for incurable conditions, as the doctor can administer treatment ‘...in rare cases where the patient or his/her guardians [in case of incapacity] are legally required to seek treatment, like some infectious diseases from which

²⁵² Ibid. request 5.

²⁵³ CEHP2013 chapter 15(A) p. 50.

²⁵⁴ M Ibn Aabidin, *Radd al-Muhtarāla Ad-Durr al-Mukhtar (Answer to the Perplexed: An Exegesis of ‘The Choicest Gems’)* (Dar Alfaker publisher 2000) volume 6 p. 338 (Arabic).

²⁵⁵ CEHP2013 chapter 15(A) p. 50.

²⁵⁶ Ibid.

²⁵⁷ Ibid.

²⁵⁸ Ibid.

there is fear of spread'.²⁵⁹ Thus, CEHP2013 has recognised that doctors can enforce treatment in certain circumstances of incurable illness in the public interest, but, apart from this situation, it seems to acknowledge that patients have the right to refuse even *Wajib* treatment based on full knowledge about the case.

Therefore, Saudi Arabia likely seems to acknowledge that in respect of incurable illness, if a doctor has informed the patient in detail and explained the risks, available treatment and the consequences of the refusal, the doctor should not be considered ethically and religiously wrong for not proceeding with treatment that the patient has refused.²⁶⁰ This is so even if refusal of treatment is likely to hasten death, or cause the patient's condition to deteriorate faster than it would otherwise have done. Where the doctor has done what he can to convince the patient to consent, the holy *Quran* states that a person should not go beyond his limit of advice and persuasion.²⁶¹

ii. *Moharam* treatment

Doctors are ethically and religiously accountable; hence if the doctors respect patient consent to seek *Moharam* treatment or any act that is illegal under Islamic *Sharia*, they are committing sin because of their disobedience of Allah's will to preserve patients' lives and health.²⁶² Thus, doctors should not support or assist patients to do something that may cause them harm, as the holy *Quran* in translation states 'help one another in acts of righteousness and piety, and do not help one another in sin and transgression.'²⁶³ It is against Islamic *Sharia* principles, for example, to change gender for no medical reason, as the GPSRI has stated that 'it is not permissible to transform a male or female whose masculine or feminine organs are completely developed to the opposite sex... because it is considered changing the creation of Allah.'²⁶⁴ If the treatment itself is prohibited by Islamic *Sharia*, even if it does not cause

²⁵⁹ *ibid.*

²⁶⁰ For example, the GPSRI declaration in 1998 '... The Permanent Committee reviewed your [the boy's father] letter and scrutinized the above mentioned questions. The soundness of the doctors' opinion that the major illness suffered by this child is beyond hope of recovery was confirmed by the Committee. Accordingly, the Committee sees that there is no use to continue the treatment and there is no sin on you or the doctors if you allow the child to die.' at <http://www.alifta.net/Search/ResultDetails.aspx?languagename=en&lang=en&view=result&fatwaNum=&FatwaNumID=&ID=295&searchScope=17&SearchScopeLevels1=&SearchScopeLevels2=&highLight=1&SearchType=exact&SearchMoe sar=false&bookID=&LeftVal=0&RightVal=0&simple=&SearchCriteria=allwords&PagePath=&siteSection=1&searchkeywo rd=084104101032115111117110100110101115115032111102032116104101032100111099116111114115039032111 112105110105111110#firstKeyWordFound> (accessed 27/06/2015).

²⁶¹ The holy *Quran* in translation (CH2:268).

²⁶² Q AlMubarak, *Altadwi wa Almsolih Altbieh fa Alshraiah Alesslamih (Treatment and Medical Liability in Islamic Sharia)* p. 326.

²⁶³ The holy *Quran* in translation (CH 5:2).

²⁶⁴ GPSRI declaration no 176 in 1993 at

<http://www.alifta.net/Search/ResultDetails.aspx?languagename=en&lang=en&view=result&fatwaNum=&FatwaNumID=&ID=289&searchScope=17&SearchScopeLevels1=&SearchScopeLevels2=&highLight=1&SearchType=exact&SearchMoe sar=false&bookID=&LeftVal=0&RightVal=0&simple=&SearchCriteria=allwords&PagePath=&siteSection=1&searchkeywo rd=084104101032115111117110100110101115115032111102032116104101032100111099116111114115039032111 112105110105111110#firstKeyWordFound>

severe harm or death to the patient, consenting to it or providing it would be ethically and religiously wrong. For example, the GPSRI has ruled in regard to the use of alcohol (wine) as treatment that: ‘Wine is Haram (prohibited) and it is not permissible to use it as a cure...’.²⁶⁵ Further, in relation to *Moharam* treatment, CEHP2013 has placed ethical duties on doctors to not proceed or respect patients’ wishes, for example, in the following:

‘1. It is not permissible to use or perform any religiously forbidden procedure or medication unless in necessary cases. These (procedures/medications) include plastic surgeries, treatment of infertility, or use of pork-derived drugs, and other forbidden things. 2. Refrain completely from doing hymenorrhaphy or hymenoplasty (hymen reconstruction surgery) whether the patient is young or old, married or not, unless for religiously permissible conditions. 3. Refrain from treating infertility with religiously impermissible methods. 4. Refrain from religiously forbidden plastic surgeries.’²⁶⁶

If a patient consents to *Moharam* treatment that leads to death or severe harm or to something that is against Islamic *Sharia* principles, he/she has committed a sin, because of his/her disobedience of Allah’s will and because he/she is putting him/herself and his/her health in a hazardous situation, so he/she is both religiously and ethically wrong.²⁶⁷ Consenting to *Moharam* treatment which results for example in his/her death or severe harm would be sometime considered an act of suicide, which is banned by Islamic *Sharia*: ‘and do not kill yourselves [or one another]. Indeed, Allah is to you ever Merciful.’²⁶⁸ Even if there is no harm as a result, the patient’s consent is both sinful and unethical and doctors who proceeded with such treatment would also be regarded as guilty of a sin and unethical practice.

After having discussed the issue of limitations on respect for patients’ autonomy in accordance with Islamic *Sharia* principles, the thesis will now move on to discuss the issue of where there is complete respect for patients’ autonomy to consent to or refuse treatment.

2) A complete respect for patient autonomy

A. The last three rulings

Under the last three of the five rulings, a competent adult patient who is conscious can consent to or refuse medical treatment for any reason or no reason.

rd=112101114109105115115105098108101032116111032116114097110115102111114109032097032109097108101
#firstKeywordFound (accessed 27/06/2015).

²⁶⁵GPSRI declaration no 102, no date

<http://www.alifta.net/Fatawa/FatawaChapters.aspx?language=en&View=Page&PageID=200&PageNo=1&BookID=17> (accessed 14/08/2015).

²⁶⁶CEHP2013 chapter 7(A)1,2,3 and 4 p. 32.

²⁶⁷M AlShanqeeti, *Ahkam Algerhah Altibeh w Alather Almotrtbh Aliha. (Rulings of Medical Surgeries and Their Consequences)*. p. 170-171.

²⁶⁸The holy *Quran* in translation (CH 4:20).

(i) The treatment is *Makroh* (blameworthy) for the patients to seek if a treatment may lead to some risks that might be more than the suffering of the illness without treatment and it is not a case of infectious disease.²⁶⁹

(ii) The treatment is *Mandob* (praiseworthy) for patients to seek if the patient refusing it may lead to weakness in the patient's health and body. Here the suffering and harm are less than the case when the treatment is *Wajib* for the patient to seek, and it is not a case of infectious disease.²⁷⁰

(iii) The treatment is *Mobah* (indifferent) for patients to seek, where both risks and benefits of being treated are equal and do not lead to death, excluding the case of infectious disease.²⁷¹

B. The Islamic *Sharia* justification

It has been accepted by the majority of Muslim scholars that a competent adult person has the right of choice as to what may be done to his /her own body, as long as that treatment or operation is not *Wajib* or *Moharam* for him/her to seek.²⁷² Thus, a patient can refuse or consent to treatment when the treatment is *Makroh*, *Mandob* and *Mobah* for him/her to seek, whatever the reason and whatever the consequences, since death or severe harm are not expected to result.²⁷³ For example, the patient can refuse to seek treatment or be treated for a common sore throat. However, it should be noted that if the patient's health condition has worsened, the treatment might become *Wajib* for the patient to seek, thus the categorisation of the obligation to seek treatment depends on the severity of the illness itself.

This approach is taken because in these three types of seeking treatment, there is no adequate evidence to show that treatment will necessarily certainly cure the patient of an illness or lead to severe harm or death if it is refused.²⁷⁴ As a result, a competent adult patient's autonomy and autonomous decisions should be respected; the patient is free to consent to or refuse medical treatment irrespective of the reasons for, or consequences of, doing so.²⁷⁵ Thus, it is important to note that 'Islam encourages medication; but, once medication is seemingly futile; refusing, withholding, withdrawing and discontinuing such medication is

²⁶⁹ IIFA declaration no 5 (1), meeting 7 in 1992.

²⁷⁰ Ibid.

²⁷¹ Ibid.

²⁷² M AlShanqeeti, *Ahkam Algerhah Altibeh w Alather Almotrtbh Aliha. (Rulings of Medical Surgeries and Their Consequences)*, p. 171.

²⁷³ Q AlMubarak, *Altadwi wa Almsolih Altbieh fa Alshraiah Alesslamih (Treatment and medical liability in Islamic Sharia)* p. 197.

²⁷⁴ M Ibn Aabidin, *Radd al-Muhtarala Ad-Durr al-Mukhtar (Answer to the Perplexed: An Exegesis of 'The Choicest Gems')* volume 6 p. 338.

²⁷⁵ H Aljubayr, 'Alakte Atabih Fe Mezian Algade (Medical Errors on Judiciary Scales)' (2004) 22 *AlAdl* 140- 152 p. 144. (Arabic).

allowed...'²⁷⁶ In other words, it is not required that treatment be given or taken where it may have a low prospect of benefit or where the patient's health will not be severely harmed or there is no definite likelihood of death, or where the attempt at cure is likely to lead to great pain or suffering.

C. The religious and ethical consequences

In the case of *Makroh* (blameworthy), *Mandob* (praiseworthy) and *Mobah* (indifferent) treatment, doctors have an ethical duty to respect patients' wishes to either consent to or refuse medical treatment, so doctors should be considered to be ethically and religiously wrong if they do not respect patients' wishes.²⁷⁷

Muslim scholars have recognised that a person's human dignity should be respected in *Makroh*, *Mandob* and *Mobah* treatments since there is no evidence that they would result in the patient's death or severe harm.²⁷⁸ Thus, if a competent adult patient refuses medical treatment he/she does not commit a sin and he/she should not be ethically wrong.²⁷⁹

In conclusion, the above discussion shows that while the Islamic *Sharia* recognises and supports respect for the competent adult patient's autonomy, it is considered in a certain way. That is different from the Western view, as Islamic medical ethics is purely based on Islamic *Sharia* traditions.²⁸⁰ Thus, it can be said that what has been considered by Western medical ethics to some extent may not be compatible with the Islamic *Sharia* approach, for example the concept of the principle of respect for autonomy, regardless of the outcome (although treatment may in some cases be unlawful). Based on the understanding of Islamic *Sharia* of the purpose of medicine, the principle of respect for autonomy can be illustrated in the approach to a patient's consent or refusal of treatment. If this would not lead to death or severe harm or commit an act that is against Islamic *Sharia* principles, the competent adult patient can make his/her autonomous decision and enjoy respect for that autonomy. If Islamic *Sharia* principles were breached, then respect for the competent adult patient's autonomy would be limited. Failure to adhere to Islamic *Sharia* principles would be regarded as sinful and in breach of medical ethics in the situations discussed. The legal consequences will be considered in Chapter four. This approach of Islamic *Sharia* has important

²⁷⁶ M Yousuf and A Fauzi 'Euthanasia and Physician-Assisted Suicide: A Review from Islamic Point of View' p. 64-65.

²⁷⁷ M AlShanqeeti, *Ahkam Algerhah Altibeh w Alather Almotrtbh Aliha. (Rulings of Medical Surgeries and Their Consequences)*. p. 368.

²⁷⁸ E Anna et al. 'Communicating with Muslim Parents: 'the Four Principles' are not as Culturally Neutral as Suggested' p. 1384-1385.

²⁷⁹ M AlShanqeeti, *Ahkam Algerhah Altibeh w Alather Almotrtbh Aliha. (Rulings of Medical Surgeries and Their Consequences)*. p. 171-172.

²⁸⁰ R Veatch *A Theory of Medical Ethics* (1sted Basic Book 1981) p. 56-58.

consequences for the appropriate ethical approach to seeking consent to treatment and to information disclosure.

Therefore, in the following part, this Chapter will examine the principle of respect for autonomy in respect to the requirement for information disclosure in accordance with Islamic *Sharia*. As with the discussion of consent, there are few sources that have specifically dealt with this issue. However, I have drawn points from those that are available and, because of the limited reference to the Islamic *Sharia* sources and Saudi Arabian medical ethics, I will also refer here to commentators' views, where they have based them on their understanding of Islamic *Sharia* sources.

5.2. The importance of information disclosure and respect for autonomy

Since there is no straightforward reference in the Islamic *Sharia* sources that has specifically dealt with the issue of information disclosure, I will refer to a general statement in Islamic *Sharia* sources that can be applied to the issue.

The Messenger PBUH said: 'Leave that which makes you doubt for that which does not make you doubt.'²⁸¹ Based on this statement it can be argued that one of the Islamic *Sharia* principles places importance on *Yaqin* (certainty) when a person is considering making a decision.²⁸² Further, an Islamic Legal formula²⁸³ states: 'To imagination without foundation in fact, no weight is given.'²⁸⁴ Thus, it can be said that, for autonomy to be respected in terms of making a decision, it is fundamental from the Islamic *Sharia* perspective that the decision should be based on knowledge and information.²⁸⁵ For a decision to be respected based on the Islamic *Sharia* understanding, it must be built on clear reasoning and information.²⁸⁶ Hence, 'it could be possible to say that absolute knowledge is predominant to individual autonomy'.²⁸⁷ Therefore, I would argue that the right of patients to receive information can be established in Islamic *Sharia* medical ethics based on doctors' duties to respect autonomy,

²⁸¹ A ALNasai *Sunan an-Nasai* at <http://sunnah.com/nasai/51/173>(accessed 30/07/2015).

²⁸² Y Mustafa 'Islam and the Four Principles of Medical Ethics' p. 480.

²⁸³ Legal formulae 'are theoretical abstractions, usually in the form of short epithetical statements, that are expressive, often in a few words, of the goals and objectives of the *Shariah*. This is so much so that many ...(scholars) have treated them as a branch of the maqasid (goals and objectives) literature. The legal maxims of fiqh are statements of principles that are derived from the detailed reading of the rules of fiqh on various themes.' M Kamali 'Qawaid Alfqh: The Legal Maxims of Islamic Law' at http://www.sunnah.org/fiqh/usul/Kamali_Qawaid_al-Fiqh.pdf(accessed 19/12/2014).

²⁸⁴ The Mejlle Being an English Translation of Majallah El-Ahakam-I-Adliya and a Complete Code on Islamic Civil Law. Translated by C Tyser, D Demetriades and I Effendi. (The other press 2010) article 74.

²⁸⁵ S Aksoy and A Elmali 'The Core Concepts of the 'Four Principles' of Bioethics as Founded in Islamic Tradition' p. 216.

²⁸⁶ H fadel 'Ethics of Clinical Research: An Islamic Perspective' p. 63.

²⁸⁷ S Aksoy and A Tenik 'The 'Four Principles of Bioethics' as Found in 13th Century Muslim Scholar Mawlana's Teachings' p. 3.

since it must be understood that, under any concept of respecting choice, sufficient information is required to make that choice.

5.2.1. Doctors' duty to disclose information

In order to understand the stance of Islamic *Sharia* and Saudi Arabian medical ethics on information disclosure, I will quote a statement in CEHP2013 which has recognised an ethical duty on doctors to provide information. It should be remembered that CEHP2013 is both an ethical and a legal code so I will reconsider the same statements in Chapter four when I discuss the topic from a legal angle. Based on this, I will consider the following issues: doctors' duty to inform patients, what kind of information should be given, the issue of understanding, the acknowledgment of therapeutic privilege and patients' right to refuse information. In addition to this statement, I will apply Islamic *Sharia* general principles that can be used to refer to this duty.

CEHP2013 has stated that:

‘The healthcare practitioner should present enough information in a language that the patient can understand about what he/she [the doctor] will do, and what is required from the patient, the possible consequences of the patient's decisions, as well as potential complications and risks.’²⁸⁸

Based on the above statement it is clear that doctors have an ethical duty to inform their patients. Islamic *Sharia* has considered the requirement for information disclosure as a means of respecting patient autonomy but it may also be justified by the concept of doctors needing to act with truthfulness and to provide appropriate advice.²⁸⁹ The holy Quran in translation states in general that: ‘O believers, do not stray from the path of God, and be with those who are truthful.’²⁹⁰ From this, it can be understood that, as part of Islamic *Sharia* medical ethics regarding doctors' characters, doctors should be truthful, kind, modest and advisers to their patients.²⁹¹ Such an acknowledgment by Islamic *Sharia* and CEHP2013 shows the recognitions of doctors' ethical duty to disclose information to patients. Having established that, the question which presents itself here is what information should be disclosed?

²⁸⁸ CEHP2013 chapter 2 (C)1. p. 17.

²⁸⁹ M AlShanqeeti, *Ahkam Algerhah Altibeh w Alather Almotrtbh Aliha. (Rulings of Medical Surgeries and Their Consequences)*. p. 311-317.

²⁹⁰ The holy *Quran* in translation (CH 9:119).

²⁹¹ T Arawi 'The Ethics of the Muslim Physician and the Legacy of Mohammad' (2011) 43 *JIMA* 53-38 p. 36-38.

5.2.2. What should be disclosed

CEHP2013 has provided the phrase ‘enough information’²⁹² to state what information should be disclosed. I would suggest that this is unhelpful because it may not only cause ethical, but also legal, uncertainty as I will discuss in Chapter four. CEHP2013 does not give a definition of what is meant by ‘enough’ information although there is some further guidance on information disclosure. CEHP2013 states in chapter 2(C)1 that information should include what the doctor is proposing to do, his instructions to the patient and ‘the possible consequences of the patient’s decisions, as well as potential complications and risks.’²⁹³ Based on the view of Islamic *Sharia* medical ethics in respecting patients’ autonomy, CEHP2013 has also stated the doctors’ duty to inform the patient as follows:

‘Tell the patient or whoever is acting on his/her behalf as soon as possible about the patient’s health condition, its causes, its possible complications, as well as the benefits of the diagnostic and therapeutic procedures. Additionally, introduce them to appropriate alternatives in diagnoses and treatment in a clear and honest way’.²⁹⁴ (The statement will be further discussed in Chapter four).

The key factor here is that doctors are under an ethical (and a legal) duty to provide patients with ‘enough information’. Nonetheless, there remains a lack of clarity both as to how the standard of ‘enough information’ is to be judged and in other specific issues relating to information disclosure to the patient.

In regard to the quality of the provided information, it should be accurate and reflect the state of the patient’s condition, as doctors have a duty to tell the truth, which derives from a basic principle of Islamic *Sharia* that not telling the truth is a very serious sin. In one of Messenger’s PBUH sayings: ‘...Falsehood leads to vice and vice leads to the Fire (Hell), and a person persists on telling lies until he is enrolled as a liar.’²⁹⁵ Hence, Muslim doctors should normally provide the patient with correct and accurate information, although there may be an exception to that which I will discuss below in regard to the notion of therapeutic privilege. In most cases, however, telling the truth would be regarded as essential and, in addition to the principles mentioned, it has been claimed that the patient-doctor relationship is based on trust.²⁹⁶ The concept of trust also requires doctors to be truthful with patients, and not to exaggerate about the case.²⁹⁷ Therefore, in providing patients with information that they ask for or need, doctors should tell the patient truthfully information that accurately

²⁹² CEHP2013 chapter 2(C) 1.P. 17.

²⁹³ Ibid.

²⁹⁴ Ibid. chapter 2(B)3 p. 17.

²⁹⁵ Y Al-Nawawi *Riyad as-Salihin* at <http://sunnah.com/riyadussaliheen/1/54> (accessed 27/06/2015).

²⁹⁶ M AlShanqeeti, *Ahkam Algerhah Altibeh w Alather Almotrtbh Aliha. (Rulings of Medical Surgeries and Their Consequences)*. p. 312-313.

²⁹⁷ Ibid.

reflects the nature of the patient's condition and the course of treatment that should be taken.²⁹⁸

To demonstrate what information should ethically be disclosed, I would argue that it would be useful to consider Western medical ethics which were discussed in Chapter one. Full disclosure may be proposed as an ethical ideal, but as I have explained, there are difficulties with setting this as a legal/ethical standard for information disclosure. The same difficulties would arise if it were considered that Islamic *Sharia* required full information disclosure in order to meet the appropriate standard. However, I would argue that the ethical standard of care I have proposed in Chapter one, to provide the patient with sufficient and understandable information to enable him/her to be self-determining, is also compatible with Islamic *Sharia* medical ethics. Islamic *Sharia* general principles focus on providing truthful and accurate information in order to assist the patient to make his or her own decision, and this is in line with a requirement upon doctors to provide sufficient information. This is also supported by CEHP2013 which requires doctors to disclose 'enough' information which may be regarded as being the same as 'sufficient' information. The principal problem remaining is in establishing whether the standard has been met, whether doctors or the patient's perspective should be used.

My argument is that Islamic *Sharia* principles, while focusing on doctor's duties of truthfulness and emphasising the concept of trust, have at their heart the same reason for requiring information to be disclosed as in the Western tradition; namely, to protect patient autonomy. While there are more limitations on patient autonomy under Islamic *Sharia*, the need for disclosure of information so that the patient can make an informed decision is the same, although the consequences in terms of respecting the decision that has been made may differ from those which would be advocated under the approach to individual autonomy in Western medical ethics.

Accordingly, what follows from this in applying Islamic *Sharia* principles is that the concept of respect for autonomy needs to put an ethical duty on doctors to disclose sufficient and understandable information to enable a competent adult patient to be self-determining and to respect his/her autonomy. The way in which Saudi Arabian medical law has approached this issue will be considered in Chapter four. As well as the need for information to be sufficient, my proposed ethical standard from Chapter one also requires consideration of the issue of patient understanding, which is dealt with next.

²⁹⁸ Ibid.

5.2.3. Doctors' duty to ensure the patient can understand the information

CEHP2013 has stated that 'enough information' should be provided in an understandable language for the patient.²⁹⁹ That may suggest it is not enough just to supply the patient with information: that information should also be understandable. However, the phrase '...in a language that the patient can understand'³⁰⁰ seems to refer only to the language itself being understandable, not to a doctors' duty to ensure the patient can understand the information, which is rather different. CEHP2013 has no further explanation of what the doctor's duty to ensure that the patient can understand the given information might be, so the notion of a wider duty to seek to ensure that the patient has understood remains unclear. This issue has not been addressed in legislation either. This suggests that there is a significant absence of recognition of an important aspect of a doctors' duty in Saudi Arabian medical ethics and also in its law.

However, such a duty can be based on Islamic *Sharia* general principles. Muslims have a duty to give advice to one who seeks or needs it, as Messenger PBUH said that Muslims should give counsel to people about what would be of benefit to or suitable for them.³⁰¹ Therefore, it can be understood that one of the doctors' obligations, placed on them as an ethical and religious duty, is to give advice to the patient. That advice should be truthful, clear, and understandable and relate to the patient's case,³⁰² because normally a patient is not as educated and knowledgeable as their doctors about complex medical terms and procedures.³⁰³ Additionally, based on doctors' ethical and religious duty to advise, the information that is given to the patient must include a clear explanation of the diagnosis, prognosis, proposed treatment, and available and alternative treatments or operations that involve lower risks, to allow patients to judge and to make their choices in a properly informed way.³⁰⁴ For example, a doctor should not operate on a patient unless there is no other suitable way to treat him/her,³⁰⁵ and the doctor should advise the patient about available alternative treatments.

I would argue that the proposed ethical standard I have set in Chapter one can be applied to Islamic *Sharia* and Saudi Arabian medical ethics, as the patient should be provided with sufficient and understandable information to respect his/her autonomy and to be self-

²⁹⁹CEHP2013 chapter 2(C) 1.p. 17.

³⁰⁰Ibid.

³⁰¹M AlHajjaj *Sahih Muslim* at <http://sunnah.com/muslim/39/6> (accessed 26/06/2015).

³⁰²T Arawi 'The Muslim Physician and the Ethics of Medicine' (2010) 42 *JIMA* 111-116 p. 113-114.

³⁰³M AlShanqeeti, *Ahkam Algerhah Altibeh w Alather Almotrtbh Aliha. (Rulings of Medical Surgeries and Their Consequences)*. p. 317.

³⁰⁴Ibid.

³⁰⁵M Ibn Qayyim alJawziyyah, *Healing with the Medicine of the Messenger* p. 29.

determining. Islamic *Sharia* considers the fundamentality of information and knowledge for a decision-making as I have above stated. In Chapter one, based on Western medical ethics it has been argued that imparting information to the patient is not enough, as that information would be only meaningful if it is understandable.³⁰⁶ Further to that, although it may be ethically ideal to ensure that the patient has understood the provided information, it is accepted that this will be difficult to achieve in practice, since even providing more information to the patient with a very clear explanation does not necessarily mean that the patient has in fact understood. Therefore, what should be aimed for as an ethical ideal in medical practice is that doctors should seek to ensure that, as far as possible, patients have understood the information by communicating with them and involving them in a clear discussion and explanation. Accordingly, doctors should have an ethical (and legal) duty to provide understandable information. This is compatible with Islamic *Sharia* principles, but at present this wider concept of the need to seek patient understanding of information has not been specifically addressed in CEHP2013 or in Saudi Arabian medical law (LPHP2005).

A final question rises here is that; considering that Islamic *Sharia* has required that a decision should be built on knowledge, whether there are circumstances in which doctors may legitimately decide to withhold information.

5.2.4. The use of the notion of therapeutic privilege

CEHP2013 recognises that doctors have a duty to disclose to patients whatever information they need or ask for, which means that generally information should not be deliberately withheld and CEHP2013 has stated that this is the case ‘...even if it [the patient’s condition] was a serious and fatal one’.³⁰⁷

It has been argued that in many respects the same principles of respect for autonomy and the need for information disclosure can be justified under both Western medical ethics and Islamic *Sharia*. However, AlBar and Pasha have observed that, although some doctors in Islamic countries have attempted to apply the Western concept of ethical standards, specifically the notion of respect for autonomy and the need to inform their patients, doctors have found difficulties in doing so in particular circumstances because this may appear to conflict with Islamic *Sharia* principles.³⁰⁸ One such situation is in dealing with elderly patients who suffer from serious illness as doctors have been said to depart from respecting patients’ autonomy by giving them more hope about the seriousness of their illness than is

³⁰⁶ See Chapter one for further discussion.

³⁰⁷ CEHP 2013 chapter 2 p. 19.

³⁰⁸ M AlBar and H Pasha *Contemporary Bioethics Islamic Perspective* p.110.

justified, so as not to cause them distress.³⁰⁹ Nonetheless, AlBar and Pasha have argued that: ‘The norms are changing rapidly and with expansion of education and globalization, the Western attitudes toward autonomy, privacy, and personal liberty are going to be more acceptable especially to the young educated generation.’³¹⁰ There is an argument that the recognition of the doctors’ duty to provide the patient with whatever information he/she wants or asks for, may be more limited under Islamic *Sharia* principles. It has been narrated that the Messenger PBUH has said that: ‘When you enter upon one who is sick, cheer him up and give him hope of a long life, for that does not change anything (of the Divine Decree), but it will cheer the heart of the one who is sick.’³¹¹ Thus, it can be argued that, based on this statement, doctors can withhold information that may cause the patient serious harm, as the prophetic statement encourages and advises those who visit the patient to comfort him/her. Therefore, when the information is distressing or the patient’s case is severe, information might be withheld in his/her own interests.³¹²

In this regard, a question was submitted to the GPSRI asking whether ‘[d]octors may sometimes need to lie to their patients concerning the diagnosis of their cases especially as the patient may get worse if they know the reality about their case. Is a doctor sinful in such a case?’³¹³ The GPSRI has ruled that: ‘It is permissible to lie to the patients if this is in their best interest and will have no harmful effects on the patient or anyone else. However, it will be more preferable and precautionary on the part of a doctor to intimate instead of explicitly lying.’³¹⁴

Although the GPSRI ruling seems to allow doctors in some situations to lie to their patients, it has indicated that it disapproves of lying. This is because lying, as I have stated above, is considered ethically and religiously wrong by Islamic *Sharia*. Further, lying to the patient about the reality of his/her health condition would breach the respect for the patient’s autonomy that Islamic *Sharia* has recognised.³¹⁵ Doctors generally have a duty to provide the patient with truthful information and honest advice for the patient to make his/her decision, as that decision should be based on accurate information and knowledge. Lying would be in breach of that.

³⁰⁹Ibid. p. 111.

³¹⁰Ibid.

³¹¹M Majah *Sunan Ibn Majah* at <http://sunnah.com/urn/1315060> (accessed 16/08/2015).

³¹²M AlBar and H Pasha *Contemporary Bioethics Islamic Perspective* p. 110.

³¹³GPSRI declaration no 6908 (no date) at

<http://www.alifta.net/Fatawa/FatawaChapters.aspx?language=en&View=Page&PageID=167&PageNo=1&BookID=17> (accessed 28/06/2015).

³¹⁴Ibid.

³¹⁵ See the discussion above in this Chapter.

I would argue that because the GPSRI was answering a specific question that contained the word ‘lie’, this led the GPSRI to use the same word. The GPRSI ruling may implicitly accept the notion of therapeutic privilege because the reason for lying to patients is because some patients ‘...may get worse if they know the reality about their case’.³¹⁶ For this reason, I would argue that if a question sought the GPSRI’s view regarding withholding information that may cause serious harm to patients it is mostly likely that the GPSRI would state a similar ruling. This is because the GPSRI has allowed doctors to lie (although Islamic *Sharia* has prohibited lying) in such cases, as doctors are doing that with a good intention: to prevent serious harm to the patient. Consequently, it is highly likely that this would lead the GPSRI to take a similar view on withholding information, since this is less ethically and religiously wrong than lying, and the doctor is doing that with the same good intention not to cause serious harm to the patient.

Thus, with the assumption that the question to GPSRI also sheds light on withholding information, the GPSRI ruling has two interesting points. To allow the withholding information (therapeutic privilege), that should be based on two conditions (1) it should be in the patient’s best interest and (2) such an act should not cause harm to the patient him/herself or others (this may be relevant to withholding information about infectious diseases).³¹⁷ Thus, it can be understood that the use of withholding information is limited. This view seems to be held by LPHP2005, as I will discuss in Chapter four.

The recognition of the notion of therapeutic privilege can be illustrated further from the instructions that CEHP2013 has set in the event of breaking bad news to the patient: doctors should provide the patient with information in simple words and in a very kind and comfortable way.³¹⁸ That is subject to doctors’ discretion, as they should ‘limit the information in a way that suits the patient’s knowledge and understanding of his/her health condition without the minutiae that would increase his/her worry’.³¹⁹

The reason for kindly telling bad news to patients can be seen as a religious duty, so as to remind the patient to be patient and comfortably accept his/her destiny,³²⁰ but that depends on the patient’s personal character. Thus, as long as the patient is a strong person and can receive such bad news doctors can inform him/her; otherwise doctors can withhold such

³¹⁶GPSRI declaration no 6908 (no date).

³¹⁷Ibid.

³¹⁸CEHP2013 chapter 2 p. 19.

³¹⁹Ibid.

³²⁰ M AlShanqeeti, *Ahkam Algerhah Altibeh w Alather Almotrtbh Aliha. (Rulings of Medical Surgeries and Their Consequences)*. p. 312-313.

distressing information. Furthermore, there is an additional reason why patients should be told of their condition, if the illness is terminal, since the patient, according to Islamic *Sharia* teaching, should write his/her will, and prepare to depart from this life to the hereafter by doing more good deeds and seeking forgiveness.³²¹ It is therefore only if informing him/her may cause serious harm, that doctors may exceptionally use another approach, such as informing his/her family in order that they may inform the patient, as the aim is to limit the patient's distress.³²² Otherwise, he/she should be given the information in a way that meets the patient's needs, even if there is no cure.

A final point here is that, if doctors breach their religious and ethical duties to provide patients with information that is required and necessary they should be religiously and ethically blamed, saving in the case where informing the patient would cause him/her serious harm.³²³

This view of Islamic *Sharia* and Saudi Arabian medical ethics to recognise the use of withholding information in rare cases, when disclosing information causes serious harm to the patient, is comparable to the Western medical ethics that have been discussed in Chapter one. The emphasis by both Islamic *Sharia* and Saudi Arabian medical ethics is to limit the use of the therapeutic privilege to cases where information would cause serious harm to the patient. This would suggest, as with Western medical ethics' view, that the withholding of information should not aim to cause the patient to change his/her decision. However, there is no clear statement on that point in Saudi Arabian law, and I would suggest that such an important issue should be addressed by way of legal reform.

Having discussed the doctors' ethical duty to disclose sufficient and understandable information, the remaining question here is whether patients have a duty to seek information.

5.2.5. Patients' duty to seek information

It should be noted that CEHP2013 does not consider the issue of patients' duty to seek information nor the case of patients' refusing or waving their right to information. As there is no straightforward reference for that issue in Islamic *Sharia* medical ethics, in the following discussion I will apply the Islamic *Sharia* general principles and commentators'

³²¹ Ibid.

³²² M AlBar and H Pasha *Contemporary Bioethics Islamic Perspective* p.110.

³²³ M AlShanqeeti, *Ahkam Algerhah Altibeh w Alather Almotrtbh Aliha. (Rulings of Medical Surgeries and Their Consequences)*. p. 317.

views to discuss these issues. Interestingly, LPHP2005 has recognised patients' right to refuse information or waive their right to be informed³²⁴ as I will discuss in Chapter four.

It can be argued that the duty to seek information does exist for patients, as they should ask questions about their health conditions in order to make their decisions. The holy *Quran* states in general that a person should ask knowledgeable people if he/she is ignorant about something.³²⁵ In addition, patients ethically and religiously must be truthful about their conditions and should provide doctors with true information and an accurate description of their health conditions in order for the doctors to treat them appropriately.³²⁶

Further, as has been discussed above, based on Islamic *Sharia*, the decision to refuse or consent to treatment should be made in the light of information, because for an autonomous decision to be respected in Islamic *Sharia* that decision must be founded on clear knowledge.³²⁷ Furthermore, without receiving information, the patient's consent to or refusal of treatment may be made on mistaken grounds and this may lead to severe pain or harm or even death.³²⁸ In other words, patients should know the basics about their case and treatment, and doctors should inform them so that proper choices can be made and appropriate treatment given.

If a patient should not make choices unless he/she has sufficient knowledge and information about the issue, it can be said that the patient should not refuse to receive such information.³²⁹ Equally, it could be argued that if Muslim doctors do not inform Muslim patients, even at the patient's request, that would be against the Islamic *Sharia* teaching to give truthful advice to patients regarding their health conditions³³⁰ except where therapeutic privilege applies.

However, if a competent adult patient refuses to receive information, there are two possibilities; first, if the patient's refusal is a result of waving his/her religious and ethical

³²⁴ LPHP2005 article 18.

³²⁵ The holy *Quran* in translation states: 'And We [Allah] did not send (Prophets) before you except men, to whom We sent divine revelations – therefore, O people, ask the people of knowledge if you do not know.' (CH21:7).

³²⁶ S Farage 'The Ethics of the Physician in the Galeno-Islamic Traditions' in J Borockopp and T Eich (eds.) *Muslim Medical Ethics* (USCP 2008) 21- 37 p. 26-28.

³²⁷ H Fadel 'Ethics of Clinical Research: An Islamic Perspective' p. 63.

³²⁸ M AlShanqeeti, *Ahkam Algerhah Altibeh w Alather Almotrtbh Aliha.*(Rulings of Medical Surgeries and Their Consequences). p. 312-313.

³²⁹ S Aksoy and A Tenik 'The Four Principles of Bioethics as Founded in 13th Century Muslim Scholar Moawlana's Teaching' p. 3.

³³⁰ M AlBar and H Pasha *Masoleet ATabeeb bein AlFqih wa AlCanoon (The Doctor's Liability Between Fiqh and Law)* (2nd ed Dar AlQlam, 2008) p. 31-33 (Arabic).

right to receive information in order to allow someone who he has appointed to receive that information instead.³³¹

In that case, the competent adult patient should not be religiously and ethically accountable, as he/she can in general exercise his/her right of mandate,³³² and the one who has been appointed by the patient to act on his/her behalf must choose what is best for the patient.³³³ The doctor's duty to provide sufficient and truthful information and advice would then need to be discharged toward the representative instead of the patient. The patient could also empower doctors to act as their representatives and make choices for them. Nonetheless, doctors should, as far as they can, share information with the patient to consider what decision should be taken.³³⁴

The second possibility is if the competent adult patient refuses to receive information but still wants to make his/her decision, either to consent to or refuse treatment, then the patient might be religiously and ethically accountable. This is because an acceptable decision from an Islamic *Sharia* perspective should be based on a clear foundation of knowledge and information, not just based on an assumption.³³⁵ In such a case, it can be learnt from Western medical ethics, as I have discussed in Chapter one that doctors should not force information on a patient who has clearly expressed his/her refusal to not be informed but should provide basic information to the patient. Accordingly, I would accept that an exceptional approach may be used such as trying to persuade patients to receive information to make a decision and, in a rare case, doctors might involve the patient's family to persuade him/her to receive the basic information.³³⁶ This needs to be more clearly addressed in Saudi Arabian medical ethics and law. If the patient still refuses, then I would argue that Islamic *Sharia* would not hold doctors accountable for not providing the information, as they have done their best to advise and may treat in the best interests of the patient.

6. Conclusion

In conclusion, this Chapter has addressed the topic of Islamic *Sharia* sources and its relation to the formation of Saudi Arabian laws. It has shown that Islamic *Sharia* has a major

³³¹Ibid. P. 32.

³³²The Mejlle Being an English Translation of Majallah El-Ahakam-I-Adliya and a Complete Code on Islamic Civil Law article 1449.

³³³ M AlBar and H Pasha *Masoleet ATabeeb bein AlFqih wa AlCanoon (The Doctor's Liability Between Fiqh and Law)* p. 31.

³³⁴ M AlBar and H Pasha *Contemporary Bioethics Islamic Perspective* p. 109.

³³⁵ The holy *Quran* in translation states 'and indeed assumption does not serve any purpose in place of the Truth.'(CH53: 28)

³³⁶ M AlBar and H Pasha *Contemporary Bioethics Islamic Perspective* p. 109.

influence on the Saudi Arabian legal system and on forming the law in the country. It has shown that the Saudi Arabian legal system in its origin, development and so forth is different from the English legal system. However, it has also been argued that there is no barrier to Saudi Arabian law absorbing principles from other jurisdictions so long as they are not opposed to *Sharia* principles. The common law tradition of English law (which, it has been suggested is in some ways similar to the tradition of Muslim scholars' reflections) facilitates reasoned consideration of the rationale of legal development, facilitating consideration of the extent to which – if at all – Saudi Arabian law could or should adopt a similar approach as medical law develops.

It has further been shown that Islamic *Sharia* recognises the importance of a general principle of respect for individual autonomy and Islamic *Sharia* jurisprudence has implicitly recognised that this requires respect for patients' autonomous decisions and choices. However, this is subject to certain conditions. As Yousuf and Fauzi have argued, '[a]utonomy is important in the decision-making process if patients are able to understand and make intelligent decisions. Further, it must be exercised within certain limits and in conjunction with responsibilities towards others.'³³⁷ The patient's decision should be built on a foundation of knowledge and awareness.³³⁸ Furthermore, Islamic *Sharia* concentrates on the individual's right to decide or choose, but it also requires this to be exercised in line with general principles defining rights and freedoms. Autonomy may therefore be limited, where that may result in death or severe harm³³⁹ or the action is against Islamic *Sharia* principles, such as when the treatment is *Wajib* (obligatory) or *Mohram* (forbidden) for the patient to seek. The Messenger PBUH has stated: 'There is no injury nor return of injury.'³⁴⁰ Therefore, a person should not cause severe harm to his/her health or allow him/herself to cause any damage to another or cause death; for example, if the doctor accepts the patient's consent to treatment that is *Moharm*, which would cause the patient harm or if the refusal may lead to death. As one of Messenger's PBUH sayings has indicated, the relationship among Muslims is strong like a single wall,³⁴¹ so each one should respect the other and take proper care and responsibility for others. Further, if the treatment or operation (even it is harmless) is against Islamic *Sharia* respect for patients' autonomy is limited and doctors must not respect such a decision or proceed with the treatment. This is because, it is not permissible to use prohibited

³³⁷ M Yousuf and A Fauzi 'Euthanasia and Physician-Assisted Suicide: A Review from Islamic Point of View' p. 63.

³³⁸ S Aksoy and A Elmali, 'The Four Principles of Bioethics as Founded in 13th Century Muslim Scholar Moawlanah's Teaching' p. 3.

³³⁹ A Sachedina 'End-life: The Islamic View' (2005) 366 *Lancet* 774-779 p. 775-777.

³⁴⁰ M Anas *Muwatta Malik* at <http://sunnah.com/urn/514340> (accessed 16/08/2015).

³⁴¹ Y Al-Nawawi *Riyadh as-Salihin* at <http://sunnah.com/riyadussaliheen/1/222> (accessed 26/06/2015).

treatment as the Messenger PBUH has said: ‘Allah has sent down both the disease and the cure, and He has appointed a cure for every disease, so treat yourselves medically, but use nothing unlawful.’³⁴² However, in other cases, the patient’s decision to consent to or refuse medical treatment will be respected – in situations that fit when the treatment is *Makroh* (blameworthy), *Mandob* (praiseworthy) and *Mobah* (indifferent) for the patient to seek.³⁴³

I have also discussed the issues that related to the Islamic *Sharia* and Saudi Arabian medical ethics’ view in regard to the notion of information disclosure. The thesis has found that, although Islamic *Sharia* and Saudi Arabian medical ethics have recognised the doctors’ ethical duty to inform patients, the standard of ethical information disclosure has not been adequately addressed. The thesis proposed standard, would give respect to patients’ autonomy to make their choice and decision in accordance with Islamic *Sharia* tradition.

The thesis’s standard of information disclosure will be examined in Chapter three against English law, which will show that it seems to some extent at least, to be achievable. This Chapter has found that the ethical standard proposed can be adopted under Islamic *Sharia* and Saudi Arabian medical ethics. However, it must be noted that since there are limits on patient autonomy, doctors may not have to abide by the decision of the patient, so there must be an addition to the ethical principles from Chapter one for Saudi Arabia, so that the standard must comply with Islamic *Sharia* principles. In fact, however, it has been argued in this Chapter that this does not affect the standard of information disclosure; only the need to respect a decision about treatment made by a patient should be in accordance with Islamic *Sharia*.

Therefore, the Western standard of care is not identical to the Islamic *Sharia* standard of care. However, although there may be limits on consent and refusal of consent under Islamic *Sharia*, this may not mean that a different standard needs to apply to information disclosure. In other words, a doctor still needs to give sufficient understandable information to enable choice in all cases where what the medical treatment that the doctor proposes is lawful and available (since the doctor cannot know what decision the patient will reach if properly informed), whereas the doctor may not have to act in accordance with the patient’s decision. Thus, the doctor, for example, needs to allow the patient to consider and make a choice about available and lawful treatment, but need not act in accordance with the choice made, depending on what that decision is and what it is about. Bearing that in mind, therefore, the ethical standard will be examined against Saudi Arabian medical law in Chapter four so as

³⁴²S Abi Dawud *Sunan Abi Dawud* at <http://sunnah.com/abudawud/29/20> (accessed 16/08/2015).

³⁴³ See the discussion above.

to examine to what extent this standard has been met by the current Saudi Arabian medical law.

Further, in this Chapter the thesis has discussed the issue of doctors' ethical duty to ensure that the patient can understand the given information, and it has found that such a duty has not been stated by CEHP2013. Thus, it can be learned from Western medical ethics that such a duty to ask doctors to take all proper steps to ensure that the patient can understand the provided information should be adopted by CEHP2013. Further in regard to the notion of withholding information, Islamic *Sharia* and Saudi Arabian medical ethics have recognised such a notion in rare cases, when that would cause serious harm to the patient. Additionally, I have suggested adoption of the Western medical ethics that withholding information should not be used as a means to seek to change the patient's decision, and that this must be stated by CEHP2013. Finally, Islamic *Sharia* medical ethics have recognised patients' duty to seek information, the duty to waive their rights to be informed and the right to refuse information. These rights should be adopted by CEHP2013 and clearly instructed doctors on what to do in such cases.

In summary, I have therefore concluded that Islamic *Sharia* places a religious and a professional ethical duty on doctors to disclose sufficient and understandable information to competent adult patients to enable them to consent to or refuse treatment. It is necessary to respect patient autonomy and self-determination in accordance with Islamic *Sharia*.

However, unlike the Western ethical approach to respect for patient autonomy discussed in Chapter one, Islamic *Sharia* places specific requirements on patients and doctors to protect and preserve health and life, which may take priority over individual choice. The scope for refusing consent and for consenting to what is considered to be harmful treatment is therefore more limited under Islamic *Sharia*. Despite this, there appears to be the same requirement to provide sufficient information to patients about their condition and treatment regardless of the ultimate decision. There is, however, scope for doctors to withhold information and even to 'lie' to patients in some circumstances and the level of information that needs to be disclosed appears in ethical guidance issues to the medical profession to leave considerable discretion to them as to what should be disclosed.

The consequences of failing to abide by Islamic *Sharia* in terms of sinfulness and breach of ethical standards have been considered in this Chapter. As noted, there is a distinction between these kinds of consequences and whether conduct is punishable by law even though the sources of the obligation may be the same. Chapter four will go on to examine what

standard is currently being used in Saudi Arabian medical law, and how it reflects Islamic *Sharia* ethics in the matter of patients' consent to treatment and information disclosure. Further, the ethical standard to disclose sufficient and understandable information to patients to respect their autonomy and to be self-determining will be examined, to suggest that Saudi Arabian law should move to adopt the prudent patient standard.

Chapter three: English law on consent and information disclosure

1. Preface

It has already been seen that the dominant ethical principle in most Western jurisdictions is respect for autonomy. While different views exist on how this is to be interpreted, at a minimum this principle requires that a competent, adult patient is given sufficient, intelligible information on which to base a decision that is right for them, even if it is not clinically optimal. In what follows in this Chapter, the English law position will be considered from an historical to a contemporary position, in order to evaluate both the influence of the principle of respect for autonomy on the current law and to identify in what way(s) this principle's importance has been developed over the years.

2. An overview of the importance of consent

A simple definition of consent is a 'permission for something to happen or agreement to do something'.¹ Proceeding on the basis of the requirement of consent as a means of respecting a person's autonomy is important from an ethical perspective (as has been discussed in Chapter one) and it is also vital from a legal point of view.² Kennedy and Grubb observed that: 'The ethical principle that each person has a right to self-determination and is entitled to have their autonomy protected finds its expression in law through the notion of consent'.³ It is therefore a basic principle under English law that a competent adult patient has the right to consent to or refuse medical treatment.⁴ The requirement of consent is principally to guarantee that there is no unwarranted interference with the bodily integrity of the person him/herself.⁵ This also protects choice, due to the legitimate expectation that a competent adult's permission will be required before physical interaction can take place. As Lord Goff stated: 'every person's body is inviolate...'⁶ and this principle means that 'everybody is protected not only against physical injury but against any form of physical molestation.'⁷ Accordingly, it has been argued that the competent adult patient's valid consent to medical treatment is what makes doctors touching, performing surgery and dealing with the patient's

¹ Oxford online dictionaries at <http://www.oxforddictionaries.com/> (accessed 14/01/2015).

² M Jones *Medical Negligence* (4th ed Sweet & Maxwell 2008) para 6.001 p. 548.

³ I Kennedy and A Grubb *Medical Law* p. 575.

⁴ For example, *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, also known *F v West Berkshire H A* [1989] 2 All E.R. 545, *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95 and *Airedale NHS Trust v Bland* [1993] A.C. 789. See also, A Grubb *et al Principles of Medical Law* (3rd ed OUP 2010) para 8.10 p. 444.

⁵ S McLean and G Maher *Medicine, Morals and the Law* p. 79.

⁶ *Collins v Wilcock* [1984] 1 W.L.R. 1172 p. 1177.

⁷ *Ibid.*

body legal.⁸ There are some limited exceptions to the need for consent, such as the treatment of an incompetent adult in an emergency.⁹ However, Lord Donaldson clearly stated the importance of gaining patients' consent, as His Lordship declared:

‘The law requires that an adult patient who is mentally and physically capable of exercising a choice *must* consent if medical treatment of him is to be lawful, although the consent need not be in writing and may sometimes be inferred from the patient's conduct in the context of the surrounding circumstances’.¹⁰ (His Lordship's emphasis)

His Lordship's statement shows that *prima facie* it is unlawful for doctors to examine or conduct a treatment upon a patient without the competent adult patient's legally valid consent. Furthermore, although consent legalises interference with the patient's body, it limits that interference to the scope of that consent, which must not be exceeded.¹¹ Furthermore, consent to treatment can be withdrawn.¹² In this way, consent protects both the patient's freedom of choice and bodily integrity.¹³ Some of those principles are similar to the stances of both Islamic *Sharia* and Saudi Arabian medical law as will be discussed in Chapter four.

3. Legal consequences of proceeding without a competent adult patient's consent

Under English law, it has been stated in *Airedale* that: ‘Any treatment given by a doctor to a competent patient which is invasive (i.e. which involves any interference with the physical integrity of the patient) is unlawful unless done with the consent of the patient; it constitutes the crime of battery and the tort of trespass to the person’.¹⁴ Therefore, the legal consequences of a treatment or operation on a competent adult patient that has proceeded without consent require to be examined further in order to demonstrate the seriousness in which violations of respect for autonomy in the sense of bodily integrity and freedom of choice are held.¹⁵ In the following, the thesis will examine the legal consequences of treating competent adult patients without consent.

⁸ J Mason and G Laurie *Mason and McCall Smith's Law and Medical Ethics* p. 71.

⁹ M Brazier and E Cave *Medicine, Patients and the Law* (5th ed Penguin Books 2011) p. 121.

¹⁰ *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95 p. 103.

¹¹ For example, *Devi v West Midlands RHA* [1980] C.L.Y. 687 and *Williamson v East London and City HA* [1998] Lloyd's Rep. Med. 6.

¹² J Herring *Medical Law and Ethics* p. 165.

¹³ A Grubb *et al. Principles of Medical Law* para 8.22 and 8.28 p. 449 and 451.

¹⁴ *Airedale NHS Trust v Bland* [1993] A.C. 789 p. 882.

¹⁵ See for examples, J Herring *Criminal Law Text, Cases, and Materials* (5th ed OUP 2012), A Simester *et al. Simester and Sullivan's Criminal Law: Theory and Doctrine* (5th ed, Hart 2013).

It will start with a brief discussion of criminal liability since, while it is important to explain how the law distinguishes between types of conduct and their consequences, criminal law is seldom involved in issues concerning consent to medical treatment.

3.1. Criminal liability

For an act to be a crime, two elements: *Actus reus* and *Mens rea* must be present. There is a Latin maxim, ‘*Actus non facit reum nisi mens sit rea*’, which can be translated as meaning that ‘an act does not make a person guilty unless his mind is guilty.’¹⁶ Therefore, the *Actus reus* is the act or conduct or offence that is banned,¹⁷ while the *Mens rea* is the ‘...criminal intention, or an intention to do the act which is made penal by statute or by the common law.’¹⁸ To establish that a doctor’s behaviour amounted to a crime (as with any citizen) both elements would need to be established.¹⁹ While the contrary could be proved, there is an assumption that doctors’ intentions in respect of their patients are benign; establishing *mens rea* would therefore be extremely difficult.²⁰

However, there are some actions where a doctor’s behaviour could amount to a crime, such as where he/she is involved in euthanasia, which is illegal even at the patient’s own request.²¹ This view coincides with both Islamic *Sharia* and Saudi Arabian law’s view as will be mentioned in Chapter four. There are other circumstances in which the infliction of grievous bodily harm to patients will be regarded as illegal, for example, female genital mutilation.²²

However, given the rarity of criminal prosecutions in the routine practice of medicine in both English and Saudi Arabian laws, criminal liability will not be further considered in this Chapter. Of greater significance to this thesis, therefore, is civil liability.

¹⁶ J Gray *Lawyers’ Latin Avad-Mecum* (New ed, Robert Hale 2006) p. 23, see also, *Haughton v Smith* [1975] A.C. 476 p. 491.

¹⁷ M Allan *Textbook on Criminal Law* (13th ed OUP 2013) p. 18, *Fagan v Metropolitan Police Commissioner* [1969] 1 Q.B. 439 and D Ormerod and K Laird *Smith and Hogan’s Text, Cases and Materials on Criminal Law* (11th ed OUP 2014) p. 642-643.

¹⁸ *Allard v Selfridge & Co Ltd* [1925] 1 K.B. 129 p. 137, *R v Venna* [1976] Q.B. 421 p. 428 and *R v Savage (Susan)* [1992] 1AC 699 p. 740.

¹⁹ For example, J Herring *Medical Law and Ethics* p. 103-104 and O Quick ‘Prosecuting ‘Gross’ Medical Negligence: Manslaughter, Discretion, and the Crown Prosecution Service’ (2006) 33(3) *Journal of Law and Society* 421–450.

²⁰ Nonetheless, doctors would rarely cause deliberate harm or death to their patients, there have been some famous cases which were tragedy and shocking to the British public such as, doctor Harold Shipman who killed some of his patients during the 1980s and 1990s.). Other form of doctors’ criminal liabilities may include the action of the gross negligence of manslaughter, where there is no need to prove that there was intention to harm patients, nonetheless it is very rare to be committed by medical staffs. For example, *R v Adomako* [1994] 1 A.C. 171 [1994] 3 All E.R. 79.

²¹ Suicide Act 1961 (SA1961) (as amended) section 2. See Chapter one for further discussion.

²² Female Genital Mutilation Act 2003, section 1 (1) and section 2.

3.2. Civil liability

There are two main types of civil action that can be brought where the adequacy of consent by a patient is at issue: battery (trespass to the person) and negligence.²³ Both are actions in tort, the former being a species of intentional tort, the latter being an unintentional tort.²⁴

For a claim in the tort of battery to succeed, there are two main elements that must be established. They will be discussed further under the related areas but they are: 1. Intention of the defendant. 2. Direct infliction of force by the defendant on another. Usually there will also be a third element: damage which occurred as a result of the defendant's action.²⁵ This can be physical or non-physical. However, it should be noted that establishing that damage has resulted from the contact is not a fundamental requirement for the tort of battery because battery itself is actionable. It will however affect the level of compensation recoverable.²⁶

By contrast, for a claim for the tort of negligence to succeed there are three major elements to be established, which will be discussed below in depth; 1. Duty of care owed by the defendant to the claimant 2. Breach of the duty of care by the defendant. 3. Causation, as the breach of the duty by the defendant must cause damage to the person.²⁷

While both kinds of claim can arise as a result of inadequate information disclosure, the two types of action differ in important respects and it is therefore necessary to consider them separately. I will start by briefly considering the action of battery as most of claims in regard to the failure to adequately inform the patients are brought under negligence. Then the action in negligence will be discussed.

3.2.1. Battery

As noted above, for the tort of battery to be established, the defendant must intend to direct force against another, though he/she need not intend the harm that resulted. It has been argued that intention might be difficult to establish,²⁸ but in some cases it can be obvious; for example if the defendant aimed an object at another person and then the defendant hit

²³ S McLean *Autonomy, Consent and the Law* p. 70-73.

²⁴ M Lunney and K Oliphant *Tort Law Text and Masteries* p. 52.

²⁵ F Trindade 'Intentional Torts: Some Thoughts on Assault and Battery' (1982) 2(2) *Oxford Journal of Legal Studies* 211-237 p. 219 and W Landes and R Posner 'An Economic Theory of Intentional Torts' (1981) 1 *International Review of Law and Economics* 127-154 p. 140.

²⁶ M Jones *Medical Negligence* para 6.004 p. 549-550.

²⁷ D Owen 'The Five Elements of Negligence' (2006) 35(4) *Hofstra Law Review* 1671-1686 p. 1674.

²⁸ M Lunney and K Oliphant *Tort Law Text and Masteries* p. 52.

the person with that object, the intention is clear.²⁹ In other situations, the defendant's intention can be inferred from the circumstances.³⁰

In regard to the second element, the need for direct contact, or what it called 'unlawful force' should be considered.³¹ The term unlawful force has raised some issues as to what is meant by it. A possible answer might be that as Holt CJ held '[t]he least touching of another in anger is a battery.'³² However, it has been suggested that touching in anger or using force is not required since the focus of the legal action is protecting bodily integrity so that even touching a person while they were sleeping might amount to a battery.³³ Nevertheless, the concept of battery is more than simply touching without explicit consent. As Lord Goff in *Collins v Wilcock*³⁴ recognised, there was a general exception 'embracing all physical contact which is generally acceptable in the ordinary conduct of daily life.'³⁵ As an example, His Lordship considered the action of 'jostling' like in ordinary events where the touching between people is unavoidable.³⁶ Lord Goff additionally recognised the lawfulness of touching someone to draw and engage his attention 'though of course using no greater degree of physical contact than is reasonably necessary in the circumstances for that purpose.'³⁷

However, in a subsequent House of Lords case, Lord Goff in *Re F*³⁸ disapproved of the use of hostility as an element of the action for battery as the requirement of hostility was 'difficult to reconcile with the principle that any touching of another's body is, in the absence of lawful excuse, capable of amounting to a battery and a trespass.'³⁹ Lord Goff's view is preferable, because hostility is an unclear and ambiguous concept, and does not sufficiently pay regard to respect for the individual's bodily integrity.⁴⁰ In medical cases, conduct complained of by patients is unlikely to amount to what could be described as hostile in intent, but it may well go beyond the bounds of everyday touching and for which consent would be expected to avoid liability in battery.

²⁹ Ibid.

³⁰ F Trindade 'Intentional Torts: Some Thoughts on Assault and Battery' p. 215-220.

³¹ *Collins v Wilcock* [1984] 1 WLR 1172 p. 1177.

³² *Cole v Turner* (1704) 6 Mod 194 per Holt C.J.

³³ M Lunney and K Oliphant *Tort Law Text and Masteries* p. 60-61.

³⁴ *Collins v Wilcock* [1984] 1 W.L.R. 1172.

³⁵ Ibid. p. 1177.

³⁶ Ibid.

³⁷ Ibid.

³⁸ *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1.

³⁹ Ibid. p. 73.

⁴⁰ S Pattinson *Medical Law and Ethics* p. 116-117.

In addition to this, it has been argued that an element of direct contact is a vital requirement for an action of battery.⁴¹ In many medical treatment situations, this is likely to be easy to establish, because doctors need to touch the patient to examine him/her or operate on him/her. In line with what has been discussed, this would amount to battery if there was no consent from a competent adult patient.⁴² On the other hand, if the doctor just prescribed a medication to the patient and the patient took that medication, such conduct would not be actionable as a battery, as there is no direct bodily contact.⁴³

Finally, as noted above, the occurrences of damage in the sense of physical or psychological injury is not necessary, because battery itself is actionable so there is no need to prove there is additional harm.⁴⁴

Hence, for patients to succeed in a claim of battery the patient would need to establish that either no consent at all was given or that his/her consent was not legally valid (as it was put in *Chatterton v Gerson*, consent was not 'real').⁴⁵ As I will go on to discuss next, there are a number of ways in which a patient may seek to establish that a purported consent was not legally valid.

One would be where the patient claims that he/she was not competent to give a legally valid consent to treatment. Competence can be defined as the ability of a person to consent to or refuse something.⁴⁶ It should be remembered that the scope of this thesis is limited to competent adult patients and as a general principle, under English law, a competent patient is considered to be in full charge of his/her own will to consent to or refuse medical treatment.⁴⁷ The issue of competence, therefore, will be dealt with only briefly.

A 'person of full age' in England and Wales is one of or over the age of 18.⁴⁸ At this age it is recognised that a person has full legal capacity, although legal capacity may be acquired for certain purposes below this age; for example, the Family Law Reform Act 1969 permits people of the age of 16 or above to provide a legally valid consent to treatment.⁴⁹ Though

⁴¹A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 150.

⁴²For example, *R v Brown* [1994] 1 A.C. 212 and *Airedale NHS Trust v Bland* [1993] A.C. 789.

⁴³S MacLean *Autonomy, Consent and the Law* p. 71.

⁴⁴M Jones *Medical Negligence* para 6.004 p. 549-550.

⁴⁵*Chatterton v Gerson* [1981] Q.B. 432 p. 443.

⁴⁶*Ibid.* p. 290-291.

⁴⁷*Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95 p. 120-121. Per Lord Reid in *S v McC: W v W* [1972] A.C. 24 p. 43.

⁴⁸Family Law Reform Act 1969, section 1 (1).

⁴⁹*Ibid.* section 8 (1).

the ability of people under the age of 16 is an interesting and controversial issue, it will not be considered further.⁵⁰ However, it is undoubtedly the case that people who have reached the age of 18 years have the legal status to consent to medical treatment or refuse it and they are presumed to be competent to do so, unless proven otherwise.⁵¹ Currently, the definition of competence seems to be settled in England and Wales by the Mental Capacity Act 2005.⁵²

Another possible route may be to claim that the patient's consent was not given voluntarily. It has been said that to describe a person as 'willing' is to say that person is in a position that he/she can make a free choice without overwhelming interference with his/her will.⁵³ Putting this into a legal framework, it has been observed that, for a patient's consent to be legally valid, it is required to be given voluntarily and freely without duress or coercion.⁵⁴ Therefore, if there is any kind of coercion⁵⁵ or undue influence⁵⁶ on the patient or if the patient's consent was based on a legally significant mistake⁵⁷ this would make the consent legally invalid.

Finally, there is the more significant issue for this thesis, that the patient has not been adequately informed about the nature of the treatment or procedure. As discussed in Chapter one, requiring consent to be obtained before medical treatment is provided is believed to be a way to allow a person to control important aspects of his/her life. Respect for patients' autonomy both in terms of their bodily integrity and self-determination is recognised through the legal doctrine of consent.⁵⁸ Hence, as a general rule a treatment cannot be administered to an adult competent patient without his/her consent, even if treatment is painless or for the patient's benefit.⁵⁹ The question here is what amounts to sufficient information disclosure to provide a legally valid consent?

⁵⁰ For further information, see for example, *Gillick v West Norfolk and Wisbech Area Health Authority and Another* [1986] AC 112. S Elliston 'If You Know What's Good for You: A Consideration of Refusal of Consent to Medical Treatment by Children' in S McLean (ed.) *Contemporary Issues in Law, Medicine and Ethics* (Dartmouth 1996) 29-55.

⁵¹ *Re MB* [1997] 2 FLR 426. See now the MCA2005.

⁵² See Mental Capacity Act 2005 section 1(2), section 2(1 and 3) and section 3(1) (a, b, c and d).

⁵³ Per Scott LJ in *Bowater v Rowley Regis Corporation* [1944] K.B. 475 p. 479. See also, L Roberts 'Informed Consent and the Capacity of Voluntarism' (2002) 159 *Am J Psychiatry* 705-712 p. 709.

⁵⁴ *Latter v Braddell* [1881] 50 LJQB 448 CA.

⁵⁵ See for example, *Latter v Braddell* [1881] 50 L.J. Q.B 448 CA, *Freeman v Home Office* [1984] Q.B. 524, *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95, *Airedale NHS Trust v Bland* [1993] A.C. 789, L Curzon and P Richards *The Longman Dictionary of Law*. p. 102, R Faden and T Beauchamp *A History and Theory of Informed Consent* p. 339 and P Bean *Mental Disorder and Legal Control* (1sted CUP 1986) p. 139.

⁵⁶ See for example, *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95, *Mrs U v Centre for Reproductive Medicine* [2002] EWCA Civ 565 para 15 and S Pattinson 'Undue Influence in the Context of Medical Treatment' (2005) 5(4) *Medical Law International* 305-317 p. 305.

⁵⁷ See for example, *Appleton v Garrett* [1996] P.I.Q.R. P1, *R v Richardson (Diane)* [1999] Q.B. 444, *R v Naveed Tabassum* [2000] 2 Cr. App. R. 328 and E Jackson *Medical Law Text, Cases and Materials* p. 283.

⁵⁸ A Grubb *et al Principles of Medical Law* para 8.01 p. 439-440.

⁵⁹ *Re F (Mental Patient: Sterilisation)* [1990] 2 A.C.1.

The approach of English law to considering whether a competent adult patient's consent furnishes a defence to battery is to require what is called a 'real consent', as Bristow J stated in *Chatterton*.⁶⁰ The case was the first under English law to consider the concept of battery in medical cases.⁶¹ It is significant because it sought to draw a distinction between failures of information disclosure that would invalidate consent, and hence lead to an action in battery, and failures which would not invalidate consent but which should be dealt with instead by an action in negligence. It involved a patient who was in need of an operation to remove the pain associated with the scar of a previous hernia operation. The doctor was a specialist in this kind of pain treatment and the operation relieved the pain but only temporarily. The doctor gave the patient an injection, which was unsuccessful in removing the pain and caused the patient to lose the sensation in her right leg, which affected her mobility.⁶² The patient claimed that her consent was not legally valid as the doctor did not inform her about the risks.⁶³ The case failed in battery, because the patient had understood the general nature of the operation and '...she was under no illusion...' ⁶⁴ about it so her consent was real.

Bristow J established that:

'It is clear law that in any context in which the consent of the injured party is a defence to what would otherwise be a crime or civil wrong, the consent must be real....In my judgment once the patient is informed in broad terms of the nature of the procedure which is intended and gives her consent, that consent is real...' ⁶⁵

Bristow J held that '...the cause of the action on which to base a claim for failure to go into risks and implications is negligence, not trespass'.⁶⁶ He justified his judgment not to consider the action as battery because: '...it would be very much against the interests of justice if actions which are really based on a failure by the doctor to perform his duty adequately to inform were pleaded in trespass'.⁶⁷ Therefore, Bristow J's judgment importantly established that a consent deemed to be 'real' in the sense described can be a defence for doctors against the claim of battery.⁶⁸ Therefore, it seems likely that a consent that includes two elements – provision by the doctor of broad information of the nature of the treatment or medical

⁶⁰*Chatterton v Gerson* [1981] Q.B. 432 p. 442-443.

⁶¹J Mason and G Laurie *Mason and McCall Smith's Law and Medical Ethics* p. 113.

⁶²*Chatterton v Gerson* [1981] Q.B. 432 p. 432.

⁶³*Ibid.*

⁶⁴*Ibid.* p. 443.

⁶⁵*Ibid.* p. 442-443.

⁶⁶*Ibid.*

⁶⁷*Ibid.* p. 443.

⁶⁸See *Hills v Potter and Another* [1984] 1 W.L.R. 641. Where the approach of *Chatterton* was approved.

procedure and consent by the patient to that treatment or procedure – would prevent a doctor from accountability in battery.⁶⁹

However, from the case law derived from *Chatterton* it seems now that an action based on the tort of battery can only be raised where the competent adult patient has been treated with no consent at all or where he/she has refused consent.⁷⁰ It appears that the courts have restricted the application of the tort of battery in cases of the failure to disclose adequate information and prefer the matter to be brought on the grounds of negligence.⁷¹ Jackson argued that medical treatment that could be dealt with through the tort of battery has become rare, as it may be difficult for patients to convince the court that their consent was not legally valid as a result of inadequate information disclosure due to the way in which the courts have approached these issues.⁷² As a result, most cases where it has been alleged that there has been a failure to disclose to adequate information to the patient will be dealt with under the tort of negligence. This preference of English law to consider most failures to provide adequate information to patients as negligence claims will be seen to be similar to that of Saudi Arabian medical law. This will be discussed further in Chapter four.

Having therefore examined the action of battery, the legal requirements for a valid consent and the way that the courts have distinguished between claims that can be heard in battery and those that must be heard in negligence it is now time to turn to this second civil action to examine it in greater detail.

3.2.2. Negligence

Under this topic, the thesis will examine the failure to provide competent adult patients with adequate information that they require to make a decision regarding proposed treatment, and how that failure would be considered under the legal action of negligence. This will include discussions of the duty of care and the breach of the duty of care, with reference to three different standards of care. It will explore the development of the standard of care in the UK in relation to the issues the thesis has highlighted in the beginning of this Chapter. The issue of causation will be discussed as the final element.

⁶⁹ M Brazier and E Cave *Medicine, Patients and the Law* p. 122-124.

⁷⁰ J Mason and G Laurie *Mason and McCall Smith's Law and Medical Ethics* p.113.

⁷¹ M Jones *Medical Negligence* para 6.003 p. 549.

⁷² E Jackson *Medical Law Text, Cases and Materials* p. 215.

3.2.2.1. Information disclosure and negligence

Information is one of the vital elements to a patient being able to consider whether to give consent to medical treatment. However, as has been discussed, the consequences of failing to obtain a legally valid consent from a competent patient differ from those where a legally valid consent has been obtained but without the provision of adequate information about risks and alternatives to treatment. The former results in either civil or criminal actions in battery, trespass to the person or assault; the latter are dealt with by the civil tort concept of negligence.⁷³ Hence, '[a] claim based on negligence is apt when the claimant has given his consent to an act of the general nature of that which is performed by the defendant but there is a flaw in this consent and, as a result, there has been no consent to certain concomitant features of the act of which he was unaware'.⁷⁴

Broadly, as noted previously, there are three factors that must be established in order for a patient to succeed in a case of alleged negligence in information disclosure, and these will now be discussed in turn.

A. The Duty of Care

The concept of the duty of care has been recognised by English law for a long time.⁷⁵ It has been said that 'a duty of care is an obligation on one party to take care to prevent harm being suffered by another'.⁷⁶ It applies 'whenever one person can reasonably foresee that his conduct may cause harm to another'.⁷⁷ In *Donoghue v Stevenson*⁷⁸ Lord Atkin recognised what is called the 'neighbour principle'.⁷⁹ As His Lordship observed: 'in English law there must be, and is, some general conception of relations giving rise to a duty of care, of which the particular cases found in the books are but instances'.⁸⁰ Hence, Lord Atkin asserted that:

'You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law is my neighbour? The answer seems to be - persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.'⁸¹

⁷³Ibid. p. 176.

⁷⁴J Mason and G Laurie *Mason and McCall Smith's Law and Medical Ethics* p. 113.

⁷⁵For examples, *Winterbottom v Wright* (1842) 10 M & W 109 and *Donoghue v Stevenson* [1932] A.C. 562.

⁷⁶R Hope, J Savulescu and J Hendrick *Medical Ethics and Law: The Core Curriculum* (2nd ed Elsevier 2008) p. 51.

⁷⁷M Brazier and E Cave *Medicine, Patients and the Law* p. 178.

⁷⁸*Donoghue v Stevenson* [1932] A.C. 562.

⁷⁹R Castle 'Lord Atkin and the Neighbour Test: Origins of the Principles of Negligence in *Donoghue v Stevenson*' (2003) 7(33) *Ecclesiastical Law Journal* 210 -214 p. 210.

⁸⁰*Donoghue v Stevenson* [1932] A.C. 562 p. 580.

⁸¹Ibid.

From Lord Atkin's statement of the law it can be understood that the idea of a person's duty to others is based on the responsibility to avoid foreseeable harms to them. Therefore, a person is under a duty to avoid causing harm to another person '...who could reasonably be foreseen to be affected by our activities. Such a person is described in law as our neighbour'.⁸² Therefore, it can be argued A owes B a duty of care if A ought to take care of B's interests.⁸³ This approach is used to identify circumstances and relationships where our negligent behaviour should have legal consequences.

In terms of doctors and patients, the nature of their relationship easily gives rise to the imposition of a duty of care owed by the doctor to the patient, and it has been observed that the '...relationship itself is a source of obligations and responsibilities'.⁸⁴ Brazier and Cave state that '[a] patient claiming against his doctor, or a hospital, generally has little difficulty in establishing that the defendant owes him a duty of care'.⁸⁵ That 'little difficulty' to establish the doctor's duty of care towards a patient can be understood as only likely to arise if there is a question as to when the doctor-patient relationship came into being. Thus, for example, it has been said that a doctor is not under an obligation to treat anyone who is not his patient.⁸⁶ Further, it has been argued that under English law there is no legal obligation that requires doctors to immediately provide medical care to anyone who seeks it,⁸⁷ thus a doctor need not to say he is a doctor if a request has been made for medical assistance to a passenger in an airplane.⁸⁸ In similar situations in Saudi Arabia, Islamic *Sharia* and Saudi Arabian laws do seem to place a duty on doctors to provide medical assistance to any patient in need of treatment, as long as the patient's case is an emergency and the doctor can provide appropriate treatment. Failure to do so may attract civil or criminal liability as will be discussed in Chapter four.

However, in the case of General Practitioners (GPs) only,⁸⁹ it seems that English law under the National Health Service (General Medical Services Contracts) Regulations 2004, has imposed a duty of care on GPs toward not only to patients who are in the GPs lists,⁹⁰ but

⁸² M Corcoran 'What is Negligence?' (2000) 86 *BJU International* 280-285 p. 280.

⁸³ D Howarth 'Negligence after Murphy: Time to Re-Think' (1991) 50(1) *the Cambridge Law Journal* 58-99 p. 68-69.

⁸⁴ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 73.

⁸⁵ M Brazier and E Cave *Medicine, Patients and the Law* p. 178.

⁸⁶ *Re F (Mental Patient: Sterilisation)* [1990] 2 A.C. 1 p. 77-78.

⁸⁷ Though there has been a suggestion that Article 2 of ECHR may impose such an obligation to treat.

⁸⁸ J Mason and G Laurie *Mason and McCall Smith's Law and Medical Ethics* p. 145.

⁸⁹ A Grubb *et al Principles of Medical Law* para 3.42 p. 150.

⁹⁰ NHS Regulations 2004, Sch 6, Pt 2, para 14.

also temporary residents.⁹¹ These regulations have also extended a duty of care on GPs to attend cases outside their zone area of practice clinic,⁹² new registered patients,⁹³ patient who have not been seen for three years⁹⁴ and patients aged 75 years and over.⁹⁵ Hospitals that have an accident and emergency department owe a duty to all patients that attend irrespective if they have been hospital patients or not. When the hospitals offer emergency services it means that they are offering a public service to meet a public need, so they must accept anyone who attends.⁹⁶ It should be noted that the duty of care in the National Health Service is derived from the law of tort, because the patient does not become involved in a contractual relationship with the doctors who treat him/her.⁹⁷ In private hospitals, however, the duty of care may also be established by the contract between the parties, as either an explicit or an implied term.⁹⁸ Nevertheless, this is usually the most straightforward of the elements of a medical negligence claim as the necessary relationship for a duty of care is established in most cases when the doctor agrees to treat the patient.⁹⁹ By way of comparison, Islamic *Sharia* and Saudi Arabian laws both acknowledge that the patient doctor relationship can be considered under the law of tort or contract, as will be discussed in Chapter four.

B. Breach of the duty of care.

Doctors' duties of care in the medical field involve a number of different aspects, which include providing diagnosis, prognosis and treatment, obtaining consent; providing information to the patients and so forth.¹⁰⁰ However, as the thesis is primarily concerned with information disclosure as part of obtaining consent to treatment for competent adult patients, the discussion will be focused on that component.

In respect of information disclosure, it has been argued that '...it is now widely accepted that one aspect of the duty of care which doctors owe to their patients is to provide them

⁹¹Ibid. Sch 6, Pt 2, para 16.

⁹²Ibid. Sch 6, Pt 1, para 3.

⁹³Ibid. Sch 6, Pt 1, para 4.

⁹⁴Ibid. Sch 6, Pt 1, para 5.

⁹⁵Ibid. Sch 6, Pt 1, para 6.

⁹⁶For examples, *Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 Q.B. 428 and *Kent v Griffiths (No. 3)*[2001] Q.B. 36.

⁹⁷For examples, *Donoghue v Stevenson* [1932] A.C. 562 and *Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 Q.B. 428 and J Montgomery *Health Care Law* (2nd ed OUP 2003) p. 166.

⁹⁸R Epstein 'Medical Malpractice: The Case for Contract' (1976) 87(1) *American Bar Foundation Research Journal*. 87-149 p. 95-100.

⁹⁹*Pippin and Wife v Sheppard* (1822) 11 Price 400 p. 400.

¹⁰⁰For example, R Harper *Medical Treatment and the Law, the Protection of Adults and Minors in the Family Division*. (Jordans Ltd 1999) p. 18 and A Torda 'How far does a Doctor's 'Duty of Care' go?' (2005) 35 *Internal Medicine Journal* 295-296.

with information'.¹⁰¹ However, a significant problem is the amount and type of information that is required to be disclosed to meet the legal duty of care and the courts have adopted different approaches.¹⁰² A number of models have been proposed that seek to describe the nature of information that could be required to be disclosed. In doing so, they attempt to consider the circumstances in which a failure to provide information should result in legal liability in negligence. They provide a way of evaluating different standards of care adopted by the courts in determining whether there has been a breach of the duty of care.

Establishing what the standard of care is has importance in deciding an individual doctors' or healthcare provider's liability in negligence.¹⁰³ The patient has the burden of proof to establish that the doctor has failed to meet the standard of care that is required by the law.¹⁰⁴ Furthermore, the standard of care is vital to the law as it is applied and used by courts to examine the facts in individual cases.¹⁰⁵ As noted in Chapter one, English common law is based on a system of precedent so, in the absence of legislation which is on point, the development of law rests upon the judiciary, based on the analysis of legal principles adopted in previous case law.¹⁰⁶ An important facet of the development of the standard of care is to verify when conduct has failed to meet an appropriate standard that may enable claimants to be compensated for acts of negligence.¹⁰⁷ However, it may be argued that it is also important for the courts to determine the standard of care so it can become the accepted professional practice that doctors must follow.¹⁰⁸

In what follows the thesis will discuss three standards for information disclosure: 1. The subjective patient standard, 2. The professional (reasonable doctor) standard and 3. The prudent patient standard.¹⁰⁹ The thesis considers these three standards for the following reasons: Firstly, to show the alternative positions that might be taken toward a legal standard of care in information disclosure and the implications of these different approaches. Secondly, to provide a basis to compare the standard of care in terms of information disclosure in both English and Saudi Arabian medical laws. In both legal systems the

¹⁰¹ E Jackson *Medical Law Text, Cases and Materials* p. 176. See also I Kennedy and A Grubb *Medical Law* p. 277.

¹⁰² See for example, M Earle 'The Future of Informed Consent in British Common Law' (1999) 6 *European Journal of Health Law* 235-248.

¹⁰³ I Kennedy and A Grubb *Medical Law* p. 416.

¹⁰⁴ R Nelson-Jones and F Burton *Medical Negligence Case Law*. (2nd ed Butterworths 1995) p. 56.

¹⁰⁵ S Pattinson *Medical Law and Ethics* p. 77-78.

¹⁰⁶ M Zander *the Law-Making Process* p. 265-266.

¹⁰⁷ S Pattinson *Medical Law and Ethics* p. 77-78.

¹⁰⁸ M Jones *Medical Negligence* para 3.002 p. 224.

¹⁰⁹ See for example, X Zhao *The Duty of Medical Practitioners and CAM/TCM Practitioners to Inform Competent Adult Patients about Alternatives* (Springer, 2013).

professional standard of care has historically been used, but with different considerations and interpretations. Thirdly, to provide a context for evaluating the significant changes that it will be argued have been made to the standard of care in England: from an approach that provides greater protection of medical practitioners from liability to the one that shifts more emphasis to the protection of patient autonomy.¹¹⁰ Last, to examine in particular the prudent patient standard that has been considered by Lord Scarman in English law in the landmark case of *Sidaway*¹¹¹ and which more recent cases appear to have moved towards, culminating in the UK Supreme Court case of *Montgomery*.¹¹² The scope for adoption of this standard in Saudi Arabia will be discussed in later Chapters. Therefore, the focus will be on these three standards, which will be vital to the considerations of this thesis.

The subjective (patient) standard

The subjective patient standard is a standard that requires doctors to disclose whatever material information is necessary – according to that individual patient’s circumstances, conditions, beliefs, historical family health and so forth – for the patient to be able to properly make a decision.¹¹³ It is therefore based on the subjective (individual) needs of that patient for information to be sufficiently self-determining. The subjective standard recognises that one individual patient may have a different need for information to another and places a duty on doctors to provide information based on a single patient’s priorities, interests and needs.¹¹⁴ It has been argued that the importance of a subjective standard based on the materiality of information to an individual patient is that it enables the patient to give a properly informed consent.¹¹⁵ It permits the individual patient to decide what he/she wants to know rather than information disclosure being determined by what others, such as doctors, or even by what a ‘reasonable patient’¹¹⁶ might want. It would arguably most serve respect for individual autonomy to consider each patient’s values and needs instead of having a standard of care which is determined by the needs or views of others. As Chapter one has shown, there are some arguments which hold that respect for patients’ autonomy would put an ethical duty on doctors to disclose exactly what information each patient needs.¹¹⁷ Hence, the subjective standard would require a doctor to disclose all relevant facts and information

¹¹⁰ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

¹¹¹ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p 899.

¹¹² *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, para 87.

¹¹³T Beauchamp and J Childress *Principles of Biomedical Ethics* p. 127.

¹¹⁴ E Jackson *Medical Law Text, Cases and Materials* p. 186.

¹¹⁵ A Capron ‘Informed Consent in Catastrophic Diseases Research and Treatment’ (1974) 123 *University of Pennsylvania Law Review* 340-438 p. 416.

¹¹⁶ *Ibid.*

¹¹⁷T Beauchamp and J Childress *Principles of Biomedical Ethics* p. 127.

not from the perspective of the doctor's judgement of what is best for the patient, but based on what the individual patient wants to receive.¹¹⁸

Nevertheless, the subjective patient standard has been subject to significant criticism, which explains why it is rarely advocated as a legal standard of information disclosure. It has been said that it is not logical and practical to expect that doctors would know in detail what a particular patient's background, interests, beliefs and needs are,¹¹⁹ and then be able to tailor information specifically and accurately in complete accordance with the patient's needs and in relation to his or her case.¹²⁰ It has already been argued, in Chapter one, that it is not appropriate to give patients all possible information since providing too much information to a patient can hinder their decision making as much as not providing enough. Deciding accurately exactly how much information an individual patient wants, based on their individual values, aspirations and preferences, is a very difficult judgment to make. At the least, it would require the doctor to spend a huge amount of time and effort to find out about each patient's background, values, wishes and so forth, which is likely to be unachievable in practice.

There is also the danger that if injury occurred to patients as a result of an inherent risk in the treatment of which they were not warned, that they would be able to succeed in establishing a breach of the duty of care if they simply said that this information was necessary to their decision, no matter how unlikely or small the risk was. This suggests it would be difficult for the law to apply the subjective standard of care, as it would open the door wide for undeserving medical claims because, with the benefit of hindsight, patients may not tell the truth about what they needed to know to make a decision.¹²¹ While this raises issues of causation and the credibility of the patient in saying what they would have done if given additional information, it is also relevant to what standard of information should be disclosed and whether there has been a breach of the duty of care. The subjective patient standard of information disclosure relies entirely on the patient's evidence of what was important for them to know. Arguably, it would not be fair to hold doctors liable for negligence based on the subjective patient standard, because they could not be expected to know precisely what each particular patient's desires, wishes, fears and so forth are.¹²² It has

¹¹⁸J Mason and G Laurie *Mason and McCall Smith's Law and Medical Ethics* p. 117.

¹¹⁹E Jackson *Medical Law Text, Cases and Materials* p. 186-187.

¹²⁰T Beauchamp and J Childress *Principles of Biomedical Ethics* p. 127.

¹²¹J King and B Moulton 'Rethinking Informed Consent: The Case for Shared Medical Decision-Making' p. 444.

¹²²E Jackson *Medical Law Text, Cases and Materials* p. 186-187.

therefore been said that the subjective standard is inappropriate as a legal test as it would put ‘...an unfair legal burden on physicians to intuit the idiosyncratic values and interests of their patients and then leaves physicians at the mercy of their patients’ self-serving hindsight in court’.¹²³ Certainly, in terms of establishing doctors’ legal liability in negligence, it would be difficult to rely on it.¹²⁴

Nonetheless, I would agree with Jackson’s position that, although there have been criticisms of the subjective standard of care, that does not necessarily mean that the subjective standard should be entirely ‘dismissed as an impractical ideal’ at all.¹²⁵ Indeed, the subjective standard does seem to meet the thesis proposed standard of care to provide the patient with sufficient information that enables him/her to be self-determining to make his/her decision. However, it is important to recognise that this ethical ideal may not be one which can be translated entirely into a legal standard of care for the above reasons. The interests of fairness to both parties require that the standard of care set in negligence is not unachievable. Negligence does not require that the highest possible standard is reached, only that a defendant has not fallen below an appropriate minimum standard. Reasonableness is an inherent part of establishing an appropriate minimum standard of care in negligence.¹²⁶ Therefore, although I have proposed that as an ethical ideal the patient would have sufficient information to be self-determining (and this would entail him/her receiving only and all of the information that is relevant to his/her choice), there must be some recognition in law of what it is reasonable that a doctor might expect the patient to need to know, rather than the legal test being based solely on the patient’s evidence of what they wanted to know. As will be seen, this kind of approach is one that has come to be taken in English law in recent cases, such as *Montgomery*. This case, as will be discussed, has been regarded as significant in establishing a prudent patient test in English law and, as such, moving away from a professional standard. This shift will provide the basis for considering the current position adopted in Saudi Arabian law and to propose reforms, which will be discussed in Chapter four and the Concluding Chapter.

The professional and prudent patient standards are the final two of the three standards of care to be discussed and they are the ones that have been more commonly applied in practice. It can be argued that throughout the development of English law in dealing with information

¹²³ R Faden and T Beauchamp *A History and Theory of Informed Consent* p. 33.

¹²⁴ E Jackson *Medical Law Text, Cases and Materials* p. 187.

¹²⁵ *Ibid.*

¹²⁶ For example, *Donoghue v Stevenson* [1932] A.C. 562.

disclosure cases, there have been two distinguishable stages; first, the doctor-centred stage where by applying the professional standard of care doctors' views were given more priority. Second the patient-centred stage, where courts give more consideration to patients' autonomy and rights.

The Doctor-centred stage (the professional standard)

The professional standard can be described as a standard that places a duty on doctors to disclose information to patients that reasonably prudent doctors would have disclosed to patients in the same situation.¹²⁷

In *Blyth v Birmingham Waterworks Co*¹²⁸ Alderson LJ stated that 'negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do'.¹²⁹ A reasonable person has been described colourfully as 'the man in the Clapham omnibus'.¹³⁰

This test of reasonableness can also be applied to professional practice such as medicine.¹³¹ However, this test has been modified to take account of the fact that when a person is acting in the exercise of professional skills, it would not be appropriate to judge them simply against the standard of the average reasonable person. In the case of doctors, therefore, a professional practice standard was developed, initially in the leading Scottish case of *Hunter v Hanley*.¹³² The case involved a patient who was given an injection, but suffered an injury as a result of the breaking of hypodermic needle. She claimed that the injury was caused by the defender's negligence as he failed to exercise a proper standard of care and competence.¹³³ The pursuer was successful at trial, which was heard by jury, but the case was remitted to the Court of Session to consider whether the jury had been misdirected on the test for negligence. Lord President Clyde observed that:

'To establish liability by a doctor where deviation from normal practice is alleged, three facts require to be established. First of all, it must be proved that there is a usual and normal practice. Secondly it must be proved that the defender

¹²⁷ M Brazier 'Patient Autonomy and Consent to Treatment: The Role of the Law?' (1987) 7 *Legal Studies* 169-193 p. 182.

¹²⁸ *Blyth v Birmingham Waterworks Co* (1856) 11 Exch 781.

¹²⁹ *Ibid.* p. 784.

¹³⁰ Per Greer LJ in *Hall v Brooklands Auto Racing Club* [1933] 1 KB 205 p. 224.

¹³¹ *Harmer v Cornelius* (1858) 5CB (NS) 236 p. 246 'The public profession of an art is a representation and undertaking to all the world that the professor possesses the requisite ability and skill'.

¹³² *Hunter v Hanley* [1955] S.L.T. 213.

¹³³ *Ibid.* p. 213.

has not adopted that practice, and thirdly (and this is of crucial importance) it must be established that the course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care.¹³⁴

Accordingly, it was the practice of the profession, or a ‘custom test’ that was set which examines a doctor’s conduct against the normal conduct of his profession or craft.¹³⁵ This test is applied in other areas of professional negligence.¹³⁶ In regard to the medical profession, Lord President Clyde concluded that ‘the true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care’.¹³⁷ The defender’s motion was upheld and a new trial was ordered on the basis that there had been a misdirection on the law.

The test in *Hunter* was upheld in the later English case of *Bolam v Friern Hospital Management Committee*.¹³⁸ These cases therefore have formed the foundation of the establishment of the professional standard that came to be adopted by English law.¹³⁹ In *Bolam*, Bolam voluntarily agreed to be treated, as a result of the treatment, he suffered from injuries. Nonetheless, although he had consented to the treatment he claimed that (1) he was not informed about the risks associated with the treatment undertaken (negligence in information disclosure) and (2) he was not given the appropriate relaxation drug or physically restrained (negligence in treatment).¹⁴⁰ Based on the expert witnesses’ opinions as to what should have been considered in Bolam’s course of treatment, there were different views on how to proceed.

First, in terms of the alleged negligent treatment,¹⁴¹ expert witnesses agreed that there was a respected body of medical opinion that was in opposition to the use of relaxation drugs and

¹³⁴ *Ibid.* p. 217.

¹³⁵ J Mason and G Laurie *Mason and McCall Smith’s Law and Medical Ethics* p. 148.

¹³⁶ For examples, *Clark v MacLennan* [1983] 1 All E.R. 416, *Hills v Potter and Another* [1984] 1 W.L.R. 641, *Maynard v West Midlands Regional Health Authority* [1984] 1 W.L.R. 634, *Woodhouse v Wright Johnston & Mackenzie* 2004 S.L.T. 911, *Lamb v Wray* 2014 S.L.T. (Sh Ct) 2 and *Dunvale Investments Ltd v Burness Paull & Williamson LLP* [2015] CSOH 32.

¹³⁷ *Hunter v Hanley* [1955] S.L.T. 213 p. 217.

¹³⁸ *Bolam v Friern Hospital Management Committee* [1957] 1 W.L.R. 582 p. 587. See also Lord President Clyde stated that ‘the standard seems to be the same in England’ *Hunter v Hanley* [1955] S.L.T. 213 p. 217, *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 per Lord Bridge and *Moyes v Lothian Health Board* 1990 S.L.T. 444 per Lord Caplan.

¹³⁹ M Stauch and K Wheat *Source Book on Medical Law* p.152.

¹⁴⁰ *Bolam v Friern Hospital Management Committee* [1957] 1 W.L.R. 582 p. 583.

¹⁴¹ This part is out of the thesis limit, as it is focused on information disclosure only.

considered that less use of restraint would result in fewer injuries.¹⁴² McNair J gave his assessment of the legal standard to be met as follows:

‘He [a doctor] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.’¹⁴³

McNair J believed that doctors ‘...cannot obstinately and pig-headedly’¹⁴⁴ apply an old method to treat a patient ‘if it has been proved to be contrary to what is really substantially the whole of informed medical opinion’.¹⁴⁵ Therefore, for a doctor to say he would not use anaesthetics, for example, and that he would still use discredited methods to treat ‘clearly would be wrong’.¹⁴⁶ Thus, it can be said that in terms of negligence in treatment by doctors, the professional standard was applied, which places heavy reliance on expert medical evidence about practice accepted as proper by the profession.

Second, in terms of warning of risks of treatment (the alleged negligence in information disclosure), according to expert witnesses’ opinions in *Bolam* on behalf of the defendants, the practice at that time was not to warn patients about the risks of a medical treatment if doctors believed these were small, unless the patient asked.¹⁴⁷ On the other hand, Bolam’s expert witness claimed that ‘it would not be right not to warn a patient of the risks of the treatment’.¹⁴⁸ McNair J found the amount of information that was given to Bolam was in accordance with an accepted responsible body of medical opinion at that time; therefore, the doctor should not be considered negligent.¹⁴⁹

In other words, it appeared that the same approach was taken toward alleged negligent treatment and alleged negligence in disclosing information about risk. Since *Bolam* this approach to establishing whether there has been a breach of the duty of care has been cited in many different aspects of medical treatment case law.¹⁵⁰ The applicability of *Bolam*

¹⁴² *Bolam v Friern Hospital Management Committee* [1957] 1 W.L.R. 582 p. 583.

¹⁴³ *Ibid.* p. 587.

¹⁴⁴ *Ibid.*

¹⁴⁵ *Ibid.*

¹⁴⁶ *Ibid.*

¹⁴⁷ *Ibid.* p. 583.

¹⁴⁸ *Ibid.*

¹⁴⁹ *Ibid.* 587. See also C Tay ‘Recent developments in Informed Consent: The Basis of Modern Medical Ethics’ (2005) 8 *Aplar Journal of Rheumatology* 165–170 p. 168.

¹⁵⁰ For example, *Whitehouse v Jordan* [1981] 1 W.L.R. 264 in the matter of medical treatment. *Maynard v West Midlands Regional Health Authority* [1984] 1 W.L.R. 634 in the matter of diagnosis.

became central to the important case of *Sidaway v Bethlem Royal Hospital Governors*.¹⁵¹ This case is of particular interest for the extensive discussion of the appropriate standard of care and the variety of approaches taken by the judges.

The professional standard based on *Sidaway*

Sidaway suffered from a trapped nerve and consented to an operation to be relieved of the pain this caused. Unfortunately, as a result of the operation, she was left paralysed. Sidaway raised an action claiming that her doctor had been negligent, both in terms of the conduct of the treatment and, more importantly for this thesis, in that the doctor had not given her the necessary information about the risks (less than 1 per cent risk of paraplegia) involved in the surgery before she consented to it.¹⁵² In *Sidaway*, the court found that at the time of the operation some, but not all, doctors would find it acceptable not to inform Sidaway about the risks of paralysis.¹⁵³ In reaching their decision that Sidaway's action should fail, as she could not prove that the doctor breached the duty of care, the Law Lords (in the House of Lords)¹⁵⁴ presented a variety of reasons to support their judgments. Kennedy commenting on *Sidaway* that:

‘It is a fair summary to say that the House was divided three ways. Lord Scarman opted for a radical shift. Lord Diplock adopted a decidedly conservative view of the law. Lord Bridge, with whom Lord Keith concurred, and Lord Templeman chose what may be described as middle way, in what may be said to be the true tradition of the pragmatism of English law.’¹⁵⁵

Adopting Kennedy's observation, the importance of the *Sidaway* case depends on an examination of their Lordships' views regarding what standard should be applied to determine legal liability for negligent information disclosure. His approach to the categorisation of the strands of judgment is adopted below.

A decidedly conservative approach to the law (Unmodified *Bolam*)

Miola wrote that Lord Diplock in *Sidaway* treated the issue in this case as a purely legal matter, not an ethical one which involved consideration of respect for patient autonomy,¹⁵⁶ since His Lordship stated that it was ‘... a naked question of legal principle.’¹⁵⁷ Lord Diplock

¹⁵¹ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871

¹⁵² *Ibid.* p. 871.

¹⁵³ See the decision in the Court of Appeal *Sidaway v Bethlem Royal Hospital Governors* [1984] Q.B. 493 p. 523-524.

¹⁵⁴ Since 2009 the Supreme Court has replaced the Appellate Committee of the House of Lords, thus the Supreme Court is now the highest court in the country.

¹⁵⁵ I Kennedy ‘Consent to Treatment: The Capable Person’ in C Dyer (ed.) *Doctors, Patients and the Law* (Blackwell 1992) 44-71 p. 65.

¹⁵⁶ J Miola *Medical Ethics and Medical Law a Symbiotic Relationship* p. 57.

¹⁵⁷ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 892.

held that a doctor's duty of care was inseparable into different aspects depending on the type of conduct under consideration. Accordingly, it would be wrong to apply different standards to different duties: it should be one standard for all doctors' duties regarding their patients.¹⁵⁸

His Lordship stated that:

'In modern medicine and surgery such dissection of the various things a doctor had to do in the exercise of his whole duty of care owed to his patient is neither legally meaningful nor medically practicable.'¹⁵⁹

Therefore, in terms of examining doctors' liability in the provision of information about the proposed treatment to patients, Lord Diplock strongly argued that the *Bolam* test was merely a modern interpretation of the ancient rule of common law.¹⁶⁰ Thus, His Lordship was convinced that the *Bolam* test's role was clear in '...laying down a principle of English law that is comprehensive and applicable to every aspect of the duty of care owed by a doctor to his patient in the exercise of his healing functions as respects that patient'.¹⁶¹ Lord Diplock argued that 'in matters of diagnosis and the carrying out of treatment the court is not tempted to put itself in the surgeon's shoes; it has to rely upon and evaluate expert evidence.'¹⁶² However, he also observed that it would not be enough for one school of thought in medical practice to be against the doctor to establish liability,¹⁶³ as he then set out the view that it was not for the court '...to give effect to any preference it may have for one responsible body of professional opinion over another, provided it is satisfied by the expert evidence that both qualify as responsible bodies of medical opinion'.¹⁶⁴ Furthermore, it seems that Lord Diplock's approach was far away from being based on patient self-determination¹⁶⁵ as His Lordship was clearly in favour of supporting doctors' professional judgement about disclosing information rather than supporting the patient's right to information he would find relevant to making a decision about treatment. This may therefore be seen as a doctor-centred approach with a limited role for the court in evaluating the professional expertise and integrity of the expert witnesses, not in judging the correctness of their conclusion on what information should in fact have been disclosed. However, even on this approach a doctor must apply '...diligence, care, knowledge, skill and caution...'¹⁶⁶ to treat the patient. As

¹⁵⁸J *Montgomery Health Care Law* p. 244.

¹⁵⁹*Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 893.

¹⁶⁰*Ibid.* p. 892.

¹⁶¹*Ibid.* p. 893-894.

¹⁶²*Ibid.* p. 895.

¹⁶³J *Montgomery Health Care Law* p. 244.

¹⁶⁴*Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 895.

¹⁶⁵J *Miola Medical Ethics and Medical Law a Symbiotic Relationship* p. 59.

¹⁶⁶*R v Bateman* (1925) 94 LJKB 791 (CCA).

Kennedy and Grubb stated, the duty imposed by law is to exercise reasonable care to treat, diagnose and give information.¹⁶⁷ However, for Lord Diplock, that duty is ‘...as [a] single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment’.¹⁶⁸ Therefore, Lord Diplock dismissed the appeal, since applying a professional practice standard in this way he concluded there had been no breach of this duty and the patient had been sufficiently informed.¹⁶⁹ I will argue that the formulation of the *Bolam* test by Lord Diplock so as to assert that the professional standard is applicable to all medical cases, including the failure to warn the patient about risk, is similar to the way the duty to disclose is approached in Saudi Arabian medical law.

Middle way (Modified *Bolam*)

Although Lords Bridge, Keith and Templeman raised a number of issues relating to patients’ need for information, they took the view that the duty of care should be based on what a responsible professional would disclose (the professional standard), albeit that they suggested some modification of this standard.

Both Lords Bridge (with whom Lord Keith agreed) held that the starting point was that the *Bolam* test should be applied:

‘[A] particular treatment must primarily be a matter of clinical judgment. It would follow from this that the issue whether non-disclosure in a particular case should be condemned as a breach of the doctor’s duty of care is an issue to be decided primarily on the basis of expert medical evidence, applying the *Bolam* test.’¹⁷⁰

However, Lord Bridge seems to have adopted a modified *Bolam* test¹⁷¹ as His Lordship proceeded on the basis of the patients’ right to receive information,¹⁷² although that should be subject to ‘clinical judgement’ in disclosing medical information to a patient.¹⁷³ Thus, in the first place, whether a doctor has failed to disclose adequate information to the patient relies on the judgement of a responsible body of medical opinion.¹⁷⁴ Nonetheless, Lord Bridge believed that the court should have the last word on what standard of care should be set, as he noted that ‘I do not see that this [the *Bolam*] approach involves the necessity to

¹⁶⁷ I Kennedy and A Grubb *Medical Law* p.155.

¹⁶⁸ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 893.

¹⁶⁹ *Ibid.* p. 895.

¹⁷⁰ *Ibid.* p. 900.

¹⁷¹ E Jackson *Medical Law Text, Cases and Materials* p. 179.

¹⁷² A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 165.

¹⁷³ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 900.

¹⁷⁴ J Montgomery *Health Care Law* p. 244.

hand over to the medical profession the entire question of the scope of the duty of disclosure'.¹⁷⁵ Importantly, His Lordship indicated that '...if there is a conflict of evidence as to whether a responsible body of medical opinion approves of non-disclosure in a particular case, the judge will have to resolve that conflict'.¹⁷⁶ Based on Lord Bridge's views it appears that the court should play a role in judging expert evidence, which seems a departure from Lord Diplock's view, which sought to avoid this.¹⁷⁷ Lord Bridge seems to go further than this and recognises that the court may have the final say by declaring that the doctor was negligent, even though there were doctors who would accept that the action of a doctor to not disclose risks was defensible and proper.¹⁷⁸ According to Lord Bridge's view, judges may be able to prefer one school of thought over another;¹⁷⁹ consequently, the court can decide whether a school of thought's view is unreasonable.¹⁸⁰ In Lord Bridge's words:

'But even in a case where, as here, no expert witness in the relevant medical field condemns the non-disclosure as being in conflict with accepted and responsible medical practice, I am of the opinion that the judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it.'¹⁸¹

Lord Bridge suggested that information that ought to be disclosed was that '...involving a substantial risk of grave adverse consequences'.¹⁸² His Lordship then illustrated that risk by giving the example of '...the ten per cent risk of a stroke from the operation',¹⁸³ which His Lordship drew from the Canadian case of *Reibl v Hughes*.¹⁸⁴ Lord Bridge averred that, in a similar case, such a risk should be disclosed in the absence of a convincing reason 'why the patient should not be informed.'¹⁸⁵ Furthermore, His Lordship insisted that '...a doctor, recognising and respecting his patient's right of decision, could hardly fail to appreciate the necessity for an appropriate warning'.¹⁸⁶ Nonetheless, with Lord Bridge's example of a 10% risk of stroke as a basis for deciding the significant risk of adverse consequences that no prudent medical man would fail to disclose, it has been said that Lord Bridge's view could

¹⁷⁵ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 900.

¹⁷⁶ *Ibid.*

¹⁷⁷ *Ibid.* p. 895.

¹⁷⁸ J. Montgomery *Health Care Law* p. 245.

¹⁷⁹ *Ibid.*

¹⁸⁰ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 900.

¹⁸¹ *Ibid.*

¹⁸² *Ibid.*

¹⁸³ *Ibid.*

¹⁸⁴ *Reibl v Hughes* (1978) 89 D.L.R. (3d) 112.

¹⁸⁵ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 900.

¹⁸⁶ *Ibid.*

generate more legal dispute and that it would be ‘dangerous’ to depend on ‘statistical probability’.¹⁸⁷ The terms ‘substantial’ and ‘grave’ risk have been criticised, as they raise issues of who should decide what they mean and who should judge them.¹⁸⁸ Further, the reliance on the notion of percentage risk would create problems for the law as that would suggest that the law’s role would be ‘a simplistic and arithmetical one, merely concerned with expert evidence on percentages’.¹⁸⁹ Further, the use of percentages would move experts’ evidence to focus to the percentage risk involved in a treatment rather than on what information doctors should disclose to patients.¹⁹⁰ Despite concerns that Lord Bridge’s view regarding the assessment of risks that should be disclosed was not a sufficient clarification of *Bolam*, His Lordship’s view has been cited with approval in subsequent cases, such as in *Pearce v United Bristol Healthcare NHS trust*.¹⁹¹ Lord Bridge also considered whether doctors should clearly answer the questions their patients ask, and indicated that ‘the doctor’s duty must, in my opinion, be to answer both truthfully and as fully as the questioner requires’.¹⁹²

Despite this, based on the facts, the appeal was dismissed by Lords Bridge and Keith, as the information given to the patient was in accordance with a responsible body of medical opinion and the level of risk was not sufficient to require a departure from that.¹⁹³

Lord Templeman did not refer to the *Bolam* test, or specifically state which test should be applied to what information should be disclosed.¹⁹⁴ However, arguably, Lord Templeman’s view was closer to Lord Bridge’s view than the other Law Lords.¹⁹⁵ Thus His Lordship’s view can also be considered as in favour of a modified *Bolam* test. Lord Templeman supported patients’ self-determination and their right ‘...to decide whether or not to submit to treatment recommended by the doctor.’¹⁹⁶ Nevertheless, he declared that ‘I do not subscribe to the theory that the patient is entitled to know everything nor to the theory that the doctor is entitled to decide everything’.¹⁹⁷ For Lord Templeman, the reason for disclosing information is to enable the patient to make a balanced decision; hence, the doctor should

¹⁸⁷ J Montgomery *Health Care Law* p. 245.

¹⁸⁸ E Jackson *Medical Law Text, Cases and Materials* p. 179.

¹⁸⁹ I Kennedy and A Grubb *Medical Law* p. 693.

¹⁹⁰ Mason and G Laurie *Mason and McCall Smith’s Law and Medical Ethics* p. 126-127.

¹⁹¹ *Pearce v Untied Bristol Healthcare NHS trust* [1999] E.C.C. 167.

¹⁹² *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 898.

¹⁹³ *Ibid.* p. 901.

¹⁹⁴ M Jones *Medical Negligence* para 7.010 p. 656-657

¹⁹⁵ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 165.

¹⁹⁶ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 904.

¹⁹⁷ *Ibid.*

provide the patient with ‘sufficient information’ to do so.¹⁹⁸ The doctor should tell the patient about the diagnosis and the recommended treatment and the doctor must do that in accordance with his training and knowledge about what to say, which allows the patient to make the final choice.¹⁹⁹ Although Lord Templeman recognised that the patient should be provided with ‘sufficient information’,²⁰⁰ His Lordship also seems to have considered the notion of therapeutic privilege. In His Lordship’s words

‘the doctor impliedly contracts to provide information which is adequate to enable the patient to reach a balanced judgment, subject always to the doctor’s own obligation to say and do nothing which the doctor is satisfied will be harmful to the patient.’²⁰¹

This however appears to be a restricted view of the application of therapeutic privilege, as discussed earlier and the starting point is that the patient is entitled to decide for him/herself.

Lord Templeman also held that in order for the patient to make a ‘balanced judgment if he chooses to do so, the patient needs to be aware of the general dangers and of any special dangers in each case without exaggeration or concealment’.²⁰² Notably here, Lord Templeman attempted to distinguish between ‘general’ and ‘special’ risks of treatment. The precise meaning of these terms is a matter of debate which will be considered later, but for the moment what is important to note is that categorising a risk as either ‘general’ or ‘special’ had a bearing for Lord Templeman on the duty to disclose it. For general risks, if patients have been made aware ‘that a major operation may entail serious consequences’, they cannot complain about insufficient information disclosure.²⁰³ Further, in the case of general risks, doctors should wait for patients to ask specifically for more information.²⁰⁴ For a special risk Lord Templeman held that doctors should voluntarily inform patients if ‘...there is some danger which by its nature or magnitude or for some other reason requires to be separately taken into account by the patient in order to reach a balanced judgment in deciding whether or not to submit to the operation’.²⁰⁵

¹⁹⁸ *Ibid.* p. 905.

¹⁹⁹ *Ibid.* p. 904.

²⁰⁰ *Ibid.* p. 905.

²⁰¹ *Ibid.* p. 904.

²⁰² *Ibid.* p. 905.

²⁰³ *Ibid.* p. 902 and I Kennedy and A Grubb *Medical Law* p. 693.

²⁰⁴ J Montgomery *Health Care Law* p. 245.

²⁰⁵ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 AC 871 p. 902.

In fact, Kennedy and Grubb argued that Lord Templeman's categorisation of risks is just a 'distinction without a difference'.²⁰⁶ They came to that conclusion as they tried to evaluate what Lord Templeman meant by his distinction by examining the terms 'general' and 'special' risks in the light of Canadian common law, as they argued that in his judgment His Lordship seemed to reinterpret the position of the law in *Reibl v Hughes*²⁰⁷ and *White v Turner*²⁰⁸ and read them in a way that other have not.²⁰⁹ In those cases, a general risk was said to be one that attends to all medical treatments or procedures,²¹⁰ whereas a special risk is the inherent risk in a particular procedure that may occur because of either the 'nature of the procedure itself' or because of a particular circumstance that is related to a patient.²¹¹ However, what Kennedy and Grubb suggested is that Lord Templeman does not appear to have adopted this distinction in using these terms and they further argued that His Lordship's statements were not consistent.²¹² His Lordship seemed firstly to hold that a general risk that the patient needs to know about is a risk which has 'serious consequences.'²¹³ Later on His Lordship stated that: 'In the case of a general danger the court must decide whether the information afforded to the patient was sufficient to alert the patient to the possibility of serious harm *of the kind in fact suffered*.'²¹⁴ (Emphasis added). Thus, this later statement from Lord Templeman is contradictory with the first one, 'since to be aware of the *kind of harm* requires information of a different order to that needed to know that serious consequences might follow.'²¹⁵ (Emphasis added). Neither of His Lordship statements seems to use general risks in the sense used by the Canadian courts.

Kennedy and Grubb also argued that despite the lack of clarity of Lord Templeman in distinguishing between general and special risks, he sought to impose a stronger duty on doctors to disclose a special risk.²¹⁶ That can be understood from Lord Templeman's assertion that: 'There is no doubt that a doctor ought to draw the attention of a patient to a danger which may be special in kind or magnitude or special to the patient.'²¹⁷ Kennedy and

²⁰⁶ I Kennedy and A Grubb *Medical Law* p. 694.

²⁰⁷ *Reibl v Hughes* (1978) 89 D.L.R. (3d) 112.

²⁰⁸ *White v Turner* (1981), 120 DLR (3d) 269 (Ont H Ct).

²⁰⁹ I Kennedy and A Grubb *Medical Law* p. 694.

²¹⁰ *Ibid.* p. 693.

²¹¹ *Ibid.*

²¹² *Ibid.* p. 694.

²¹³ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 AC 871 p. 902.

²¹⁴ *Ibid.* p. 903.

²¹⁵ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 166.

²¹⁶ I Kennedy and A Grubb *Medical Law* p. 694.

²¹⁷ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 AC 871 p. 903.

Grubb argued that the phrase ‘special to the patient’ can only be determined by the particular patient, but the words ‘kind’ or ‘magnitude’ do not add any additional explanation if the judge of what is a special risk is the patient himself.²¹⁸ Thus, they claim that Lord Templeman’s view may suggest that doctors ‘must disclose that which the specific patient would need to know’²¹⁹ but as they point out, this was ‘of course, rejected elsewhere in the speech of Lord Templeman himself.’²²⁰

I would agree with Kennedy and Grubb’s conclusions that Lord Templeman’s speech suffers from ‘a degree of internal inconsistency.’²²¹ In places it ‘embraces a test based upon what the particular patient would wish to know’²²² but His Lordship seems for the most part to have rejected this. It seems more likely that His Lordship’s speech should be treated as a guideline based on the reasonable doctor standard of care, subject to some modification. Kennedy and Gubb concluded that Lord Templeman’s view was that ‘...medical opinion whilst relevant, was not conclusive, as in other areas of life, the court ultimately set the standard. In this, he has much in common with [L]ord Bridge.’²²³

A related matter on which Lord Templeman focused was the role of the courts in evaluating expert evidence to determine whether the standard of care had been met. In His Lordship’s speech in *Sidaway*, Lord Templeman considered that ‘it is for the court to decide, after hearing the doctor’s explanation, whether the doctor has in fact been guilty of a breach of duty with regard to information’.²²⁴ Therefore, a court could find doctors negligent if the ‘...court is satisfied that the doctor blundered and that the patient was deprived of information which was necessary for the purpose’.²²⁵ In other words, although the evidence of expert witnesses is important and the *Bolam* test is relevant, the courts retain a final supervisory power to determine whether or not medical opinion about the appropriateness of disclosing information meets the required legal threshold.²²⁶ Despite this, as with Lord Diplock, based on the facts, Lord Templeman held that the appeal should be dismissed, as

²¹⁸ I Kennedy and A Grubb *Medical Law* p. 694.

²¹⁹ Kennedy and Grubb referred to the Oklahoma case of *Scott v Bradford* 606 P 2d 554 (1979) to compare their understanding of Lord Templeman’s view.

²²⁰ I Kennedy and A Grubb *Medical Law* p. 694.

²²¹ *Ibid.*

²²² *Ibid.*

²²³ *Ibid.*

²²⁴ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 903.

²²⁵ *Ibid.* p. 905.

²²⁶ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 166-167.

His Lordship was ‘...satisfied that adequate information was made available to Mrs Sidaway.’²²⁷

To sum up what has been discussed so far on the professional standard endorsed in *Sidaway*, Lord Diplock was the only Law Lord who clearly considered the *Bolam* test to be applicable with no restriction at all on applying it in either the performance of treatment or the context of consent. As His Lordship asserted:

‘To decide what risks the existence of which a patient should be voluntarily warned and the terms in which such warning, if any, should be given, having regard to the effect that the warning may have, is as much an exercise of professional skill and judgment as any other part of the doctor’s comprehensive duty of care to the individual patient, and expert medical evidence on this matter should be treated in just the same way.’²²⁸

Lords Bridge, Keith and Templeman had concerns regarding how the *Bolam* test should be applied, as they felt that doctors should not be the only determiners of how much information patients should be given, and accordingly suggested some modification of it.²²⁹ However, Lord Templeman also seems to have given some scope for the use of therapeutic privilege to allow doctors to withhold information when disclosing such information would harm the patients.²³⁰ Indeed, Grubb observed that: ‘The need for a therapeutic privilege to withhold information that might harm the patient is at the heart of the majority view in *Sidaway* that, at least *prima facie*, *Bolam* should apply.’²³¹ (His emphasis). However, the views of the majority endorsed the *Bolam* test to a greater or lesser extent,²³² and in so doing, the professional standard. As will be discussed, this standard and how it should be interpreted has formed the basis of the development of English law until comparatively recently.

The case of *Sidaway*, however, also highlighted an alternative approach to information disclosure to the professional standard (with or without modification) in the judgment of Lord Scarman: the prudent patient standard. This is the last of the three standards of information disclosure to be considered.

²²⁷ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 905.

²²⁸ *Ibid.* p. 895.

²²⁹ *J Montgomery Health Care Law* p. 245.

²³⁰ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 904.

²³¹ A Grubb ‘Contraceptive Advice and Doctors. A Law unto Themselves?’ (1988) 47(1) *the Cambridge Law Journal* 12-14 p. 13.

²³² S McLean *A Patient’s Right to Know Information Disclosure, the Doctor and the Law* p. 122.

The patient-centred stage (the prudent patient standard)

It can be argued that Lord Scarman's judgement in *Sidaway* was the first step in placing more emphasis on patients' wishes and respecting their rights and autonomy.

The prudent patient standard requires doctors to disclose information more closely in accordance with patients' need for information to arrive at a choice than the professional standard. According to this approach, doctors must disclose relevant and material information about treatment and its risks that reasonable patients²³³ would want to know in order to make their decision to accept or refuse medical treatment.²³⁴ It is based on considering the reasonable or prudent patients' needs and wishes for information rather than relying simply on doctors' judgements about the benefits or risks of treatment. Accordingly, doctors should assess the information that needs to be given to patients based on prudent patient values.²³⁵ It has been argued that the prudent patient standard is a more appropriate means of protecting patients' interests and self-determination in decision-making than a professional standard.²³⁶ This is because the disclosure of information is focused on patients' needs, which gives them more weight in determining what is deemed to be appropriate information disclosure.²³⁷ For Kennedy, this represents a radical shift in the direction of the standard of care from that of the other Law Lords.²³⁸

Lord Scarman in *Sidaway* (a radical shift)

Lord Scarman based his approach on the American case of *Canterbury v Spence*.²³⁹ In *Canterbury* the court considered that the disclosure of risk is vital for patients to make their own decisions about medical treatment, stating that:

'[T]o bind the disclosure obligation to medical usage is to arrogate the decision on revelation to the physician alone. Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves'.²⁴⁰

This statement in *Canterbury* shows not only the role of the law in setting the standard of care, but also the court's recognition of the importance of respecting patient self-

²³³ J King and B Moulton 'Rethinking Informed Consent: The Case for Shared Medical Decision-Making' p. 445.

²³⁴ R Faden and T Beauchamp *A History and Theory of Informed Consent*. p. 32.

²³⁵ R Shandell, P Smith and F Schulman *The Preparation and Trial of Medical Malpractice Cases* (Law Journal Press 2006) p. 4-14.

²³⁶ J Mason and G Laurie *Mason and McCall Smith's Law and Medical Ethics* p. 117-119.

²³⁷ E Jackson 'Informed Consent to Medical Treatment and the Importance of Tort' in S McLean (ed.) *First Do No Harm: Law, Ethics and Healthcare* (Ashgate 2006) p. 275-276. p. 280.

²³⁸ I Kennedy 'Consent to Treatment: The Capable Person' p. 65.

²³⁹ *Canterbury v Spence* (1972) 464 F2d 772.

²⁴⁰ *ibid.* p. 784.

determination. In fact, the court in *Canterbury* placed a great emphasis on the patient's right to be informed which can be fulfilled by placing a duty on the doctor to disclose information that a prudent patient would require.²⁴¹ In other words, 'to safeguard the patient's interest in achieving his own determination on treatment,'²⁴² the court in *Canterbury* considered that it is for the law, not the medical professional, to set '...the standard for adequate disclosure'.²⁴³ This recognition of the respect due to patient autonomy and self-determination by the court in *Canterbury* was not surprising. Many decades prior to *Canterbury*, Cardozo J asserted in the famous case of *Schloendorff v Society of New York Hospital*²⁴⁴ that: 'Every human being of adult years and sound mind has a right to determine what should be done with his own body.'²⁴⁵ This classic statement demonstrates the American courts' interest in protecting patient autonomy.²⁴⁶ Thus, it can be argued that the approach shown in *Schloendorff* can be seen as the foundation of the *Canterbury* decision that has become most commonly known as the prudent patient standard.²⁴⁷ The court concluded that 'the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks that might potentially affect the decision must be unmasked.'²⁴⁸

However, it is important to note that although the court referred to 'all risks' material to the patient's decision being unmasked, it did not in fact adopt a subjective patient test. Instead, the material risks that doctors must disclose are '...when a *reasonable person*, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy'.²⁴⁹ (Emphasis added). Therefore, doctors must provide patients with any information that reasonable people would regard as significant about what is involved in their treatment.²⁵⁰ Lord Scarman in *Sidaway* expressed approval of the *Canterbury* approach, stating that 'I think the *Canterbury* propositions reflect a legal truth which too much judicial reliance on medical judgement tends to obscure.'²⁵¹ Therefore, His Lordship held that a patient's right to be informed must be protected, as he stated that:

²⁴¹S McLean *A Patient's Right to Know Information Disclosure, the Doctor and the Law* p. 88-89.

²⁴²*Canterbury v Spence* (1972) 464 F2d 772 p. 787.

²⁴³*Ibid.*

²⁴⁴*Schloendorff v Society of New York Hospital* 211 NY 125; 105 NE 92, 93 (1914) (NYCA).

²⁴⁵*Ibid.*

²⁴⁶S McLean *A Patient's Right to Know Information Disclosure, the Doctor and the Law* p. 85.

²⁴⁷*Canterbury v Spence* (1972) 464 F2d 772 p. 788.

²⁴⁸*Ibid.* p. 786-787.

²⁴⁹*Ibid.* p. 787.

²⁵⁰M Brazier and E Cave *Medicine, Patients and the Law* p. 124-126.

²⁵¹*Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 888.

‘[I]t would be a strange conclusion if the courts should be led to conclude that our law, which undoubtedly recognises a right in the patient to decide whether he will accept or reject the treatment proposed, should permit the doctors to determine whether and in what circumstances a duty arises requiring the doctor to warn his patient of the risks inherent in the treatment which he proposes.’²⁵²

Commentators such as Kennedy and Grubb and Miola observed that Lord Scarman also specifically considered the principles of respect for autonomy and self-determination.²⁵³ His Lordship argued that ‘...a doctor’s duty of care extends not only to the health and well-being of his patient but also to a proper respect for his patient’s rights, the duty to warn can be seen to be a part of the doctor’s duty of care’.²⁵⁴ Lord Scarman recognised that the doctors’ duty of care requires them both to ‘advise’ and ‘provide’ patients with information that they need as that would allow patients to ‘consider and balance the medical advantages and risks’ to make their decisions.²⁵⁵

However, Lord Scarman also limited doctors’ duty to disclose information to that which contains ‘material risk’.²⁵⁶ Following the approach in *Canterbury*, he set out the test of material risk as follows:

‘The test of materiality is whether in the circumstances of the particular case *the court is satisfied that a reasonable person in the patient’s position would be likely to attach significance to the risk*’.²⁵⁷ (Emphasis added).

Although Lord Scarman averred that material risks should be disclosed, His Lordship narrowed the duty to disclose so that it did not require full disclosure even of material risks in all circumstances.²⁵⁸ Lord Scarman recognised an ‘exception’ to allow a doctor to omit some risks from his disclosure to a patient.²⁵⁹ His Lordship therefore seems to consider that the prudent patient standard should be subject to therapeutic privilege, as he argued that:

‘...it is plainly right that a doctor may avoid liability for failure to warn of a material risk if he can show that he reasonably believed that communication to the patient of the existence of the risk would be detrimental to the health (including, of course, the mental health) of his patient.’²⁶⁰

²⁵² *Ibid* p. 882.

²⁵³ I Kennedy and A Grubb *Medical Law* p. 695 and J Miola *Medical Ethics and Medical Law a Symbiotic Relationship* p. 62.

²⁵⁴ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 885.

²⁵⁵ *Ibid.* p. 886.

²⁵⁶ *Ibid.* p. 889.

²⁵⁷ *Ibid.*

²⁵⁸ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 164.

²⁵⁹ K Hodkinson ‘The Need to Know—Therapeutic Privilege: A Way Forward’ p. 110.

²⁶⁰ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 887.

Consequently, ‘even if the risk be material, the doctor will not be liable if upon a reasonable assessment of his patient’s condition he takes the view that a warning would be detrimental to his patient’s health’.²⁶¹ On the other hand, doctors would be liable if they omitted to inform a patient about a risk if the court decided that the prudent patient would hold it to be significant.²⁶² A therapeutic privilege as the starting point for deciding what information should be disclosed was not however advocated. Neither was Lord Scarman requiring a legal standard of full disclosure of information according to a subjective patient model. Although he clearly saw this as an ideal, it was one that he regarded as impracticable. This can be understood clearly from Lord Scarman’s words: ‘Ideally, the court should ask itself whether in the particular circumstances the risk was such that this particular patient would think it significant if he was told it existed.’²⁶³ He considered the standard of such disclosure ‘...as a matter of ethics....’²⁶⁴ and came to the conclusion that: ‘The law, however, operates not in Utopia but in the world as it is: and such an inquiry would prove in practice to be frustrated by the subjectivity of its aim and purpose.’²⁶⁵ Lord Scarman’s view, has thus drawn an important distinction between an ethical ideal of respect for autonomy discussed in Chapter one, which is focused entirely on the individual patient’s exact needs for information to make a sufficiently informed decision, and a standard that can and should be imposed in law. While dismissing a subjective standard as impracticable for the law to impose, Lord Scarman held that ‘the law can, however, do the next best thing, and require the court to answer the question, what would a reasonably prudent patient think significant if in the situation of this patient’.²⁶⁶ In doing so, His Lordship acknowledged that the setting of the standard of care is a legal not medical matter; therefore, he rejected the professional standard inherent in the *Bolam* test and instead adopted a prudent patient standard.²⁶⁷ His Lordship concluded that ‘to the extent that I have indicated I think that English law must recognise a duty of the doctor to warn his patient of risk inherent in the treatment which he is proposing...’²⁶⁸ Lord Scarman applied his finding of the prudent patient standard to the case, but nevertheless he also dismissed the appeal because in his view the risk that was not disclosed was not material and there was no breach of the duty to warn.²⁶⁹ As mentioned above, Lord Scarman referred

²⁶¹ *Ibid.* p. 889-890.

²⁶² *Ibid.* p. 890. See also K Hodkinson ‘The Need to Know—Therapeutic Privilege: A Way Forward’ p. 110.

²⁶³ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 888.

²⁶⁴ *Ibid.*

²⁶⁵ *Ibid.*

²⁶⁶ *Ibid.*

²⁶⁷ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 164.

²⁶⁸ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 889.

²⁶⁹ *Ibid.* p. 890.

to the notion of therapeutic privilege in his judgement; thus the prudent patient standard is subject to it. Therapeutic privilege is considered to be an exception to the general rules of disclosure and permits withholding of information based on the judgement of the individual healthcare professional acting in what he/she considers to be in the best interests of the patient.²⁷⁰ Where a therapeutic privilege approach is adopted it has been said that a doctor might make the decision to withhold information ‘...during the consent process in the belief that disclosure of this information would lead to harm to or suffering of the patient.’²⁷¹ Harm or suffering could arise in different ways, such as where the information is itself distressing and causes the patient to suffer as a result of hearing it or where the patient refuses appropriate medical treatment, resulting in harm to health. Harms of providing information may therefore include ‘...psychological and emotional harm which affects the patient’s physical condition and ability to make decisions’.²⁷² According to this approach, ‘...a decision to be selective with information may well be taken in order to respect the right of the patient to make an informed choice later on’.²⁷³ Therefore, based on the individual doctor’s specialist knowledge and medical experience, a therapeutic privilege approach suggests that the doctor can act paternalistically to serve the patients’ best interests and to protect them from harm that could arise because of their lack of understanding of medical terminology and procedures.²⁷⁴

With the modern recognition in medical practice of the need to respect patients’ choices and rights, it might be thought that defending the notion of therapeutic privilege no longer has a place in a medical law context either.²⁷⁵ The signs were evident in England; the courts in *Sidaway* and more recently in *Montgomery*, have recognised therapeutic privilege but with limitations. They have emphasised that the application of therapeutic privilege should not be abused and not prevent the patient from making an informed choice.²⁷⁶ Furthermore,

²⁷⁰ J King and B Moulton ‘Rethinking Informed Consent: The Case for Shared Medical Decision-Making’ (2006) 32 *American Journal of Law & Medicine* 429-501 p. 441.

²⁷¹ E Etchells *et al.* ‘Bioethics for Clinicians: 2. Disclosure.’ (1996) 155 *CAN MED ASSOC J* 387-391 p. 388.

²⁷² K Hodgkinson ‘The Need to Know—Therapeutic Privilege: A Way Forward’. (2013) 21 *Health Care Anal* 105-129 p. 107.

²⁷³ L Doyal ‘Medical Ethics and Moral Indeterminacy’ (1990) 17(1) *Journal of Law and Society* 1-16 p. 9.

²⁷⁴ L Lim ‘Medical Paternalism Serves the Patient Best’ (2002) 43(3) *Singapore Med J* 143-147 p. 144.

²⁷⁵ C Richard *et al.* ‘Therapeutic Privilege: Between the Ethics of Lying and the Practice of Truth’ (2010) 36 *J Med Ethics* 353-357 p. 357.

²⁷⁶ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 AC 871 and *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

Sidaway and *Montgomery* have recognised that the patients' questions must be answered truthfully and fully.²⁷⁷ This will be considered in detail later in this Chapter.

Accordingly, it has been suggested that therapeutic privilege '...permits physicians to tailor (and even withhold) information when, but only when, its disclosure would so upset a patient that he or she could not rationally engage in a conversation about therapeutic options and consequences'.²⁷⁸ The GMC guideline appears to have acknowledged this when in guidance to doctors it stated that:

'You [doctors] should not withhold information necessary for making decisions for any other reason, including when a relative, partner, friend or carer asks you to, unless you believe that giving it would cause the patient serious harm. In this context 'serious harm' means more than that the patient might become upset or decide to refuse treatment.'²⁷⁹

Thus, this narrow formulation in the GMC guideline does not allow doctors to adopt a therapeutic privilege approach simply where it is feared that giving information would lead patients to refuse the treatment in question. Withholding information should not affect the ability of the patient to make an informed decision.²⁸⁰ In fact, the GMC guideline has been very cautious about the use of the therapeutic privilege for withholding information, it emphasised that: 'If you [doctors] withhold information from the patient you must record your reason for doing so in the patient's medical records, and you must be prepared to explain and justify your decision.'²⁸¹

It is clear that the scope for applying therapeutic privilege to be used now is narrow and even where it is applicable the GMC guideline advises that doctors 'should regularly review [their] decision, and consider whether [they] could give information to the patient later, without causing them serious harm.'²⁸² In conclusion, I would agree with Kennedy that Lord Scarman's view in *Sidaway* was a radical shift in the UK legal approach to the standard of care in information disclosure since it focused on the issue of respect for patient autonomy and self-determination.²⁸³ Although Lord Scarman's view was in the minority and it was not

²⁷⁷ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 898 and 895 and *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 27.

²⁷⁸ A Meisel and M Kuczewski 'Legal and Ethical Myths about Informed Consent.' (1996) 156 (22) *Arch Intern Med* 2521-2526 p. 2526.

²⁷⁹ 'Consent: Patients and Doctors Making Decisions Together' (2008) Section 16.

²⁸⁰ E Jackson *Medical Law Text, Cases and Materials* p. 188.

²⁸¹ 'Consent: Patients and Doctors Making Decisions Together' (2008) Section 17.

²⁸² *Ibid.*

²⁸³ Kennedy 'Consent to Treatment: The Capable Person' p. 65.

taken up immediately by subsequent case law,²⁸⁴ it can be argued that it did become influential in later cases, most significantly in the recent case of *Montgomery*. The scope for the common law to change its approach was noted by Lord Scarman himself:

‘The common law is adaptable: it would not otherwise have survived over the centuries of its existence. The concept of negligence itself is a development of the law by the judges over the last hundred years or so....It would be irony indeed if a judicial development for which the opportunity was the presence in the law of a flexible remedy should result now in rigidly confining the law’s remedy to situations and relationships already ruled upon by the judges.’²⁸⁵

It is also worth mentioning that Teff stated at the time of the judgment in *Sidaway* that the case ‘provides some basis for further development’.²⁸⁶ Since *Sidaway* was decided, the case has not been explicitly overruled as a whole, but it has been interpreted in different ways.²⁸⁷ The development of English law since *Sidaway* will be considered in the next section.

4. The development of English law on information disclosure since *Sidaway*

It is important to trace the development of the courts’ approach to information disclosure from *Sidaway* to *Montgomery* in order to demonstrate how English law has moved towards a prudent patient standard and the implications of that in protecting patient autonomy. In doing so, it is also important to examine the extent to which English law has taken into account ethical arguments regarding respect for patient autonomy. As pointed out earlier, ethical principles may require more than the law can reasonably impose. The focus in what follows will therefore be on the major legal cases that have considered the standard of care for information disclosure and which consider the kinds of issues that will be seen to be problematic in Saudi Arabia. Considering these issues will provide the basis for arguing how Saudi Arabian medical law can learn some of English law experiences on these matters and reform its own system to more adequately protect patient autonomy.

²⁸⁴ Kennedy and A Grubb *Medical Law* p. 695.

²⁸⁵ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 883-884.

²⁸⁶ H Teff ‘Consent to Medical Procedures: Paternalism, Self-determination or Therapeutic Alliance’ (1985) 101 *The Law Quarterly Review* 432 - 453 p. 450.

²⁸⁷ M Brazier and E Cave *Medicine, Patients and the Law* p. 128.

4.1. After *Sidaway* a gradual change

In some cases following *Sidaway*, it would seem that Lord Diplock's view was supported.²⁸⁸ However, the application of his judgement was not always consistent²⁸⁹ and some movement towards a more patient-centred approach can be detected.²⁹⁰

Lord Bridge's 'modified *Bolam*' judgement in *Sidaway* was adopted in the case of *Smith v Tunbridge Wells HA*²⁹¹ where a claim was brought to the court stating that if the patient had been warned of the risks of impotence inherent in a rectal operation, he would have not consented to the surgery.²⁹² Morland J acknowledged the 'inherent ethical content in the case...'.²⁹³ He quoted from a number of their Lordships' speeches in *Sidaway* but made particular reference to Lord Bridge's approach.²⁹⁴

Based on *Smith*, there are two interesting issues. The first relates to the court's role in judging the evidence given by medical experts. The case succeeded, although there was a body of competent medical opinion which accepted that in such a case a doctor need not have informed the patient about that risk. That omission was, according to Morland J, 'neither reasonable nor responsible...'.²⁹⁵ Thus, the court held that the only reasonable action in the case was to disclose the risk to the patient.²⁹⁶ *Smith* arguably, shows an example of a court being prepared to decide that, even if it is in accordance with accepted medical practice, failure to disclose information about risk can be deemed to have been negligent, because the court believes that risk ought to have been disclosed.²⁹⁷

The second interesting issue in *Smith* was in respect of whether a doctor's duty of care is simply to provide relevant information or to ensure that patients understand it. Morland J held that:

'[T]he doctor, when warning of the risks, must take reasonable care to ensure that his explanation of the risks is intelligible to his particular patient. The doctor should use language, [that is] simple but not misleading, which the doctor

²⁸⁸ See for example, *Gold v Haringey Health Authority* [1988] Q.B. 481 and *Blyth v Bloomsbury HA* [1993] 4 Med. L.R. 151 (the case was decided in 1987).

²⁸⁹ See for example, C Carr *Unlocking Medical Law and Ethics* (2nd ed Routledge 2014) p. 157-158 and J Miola *Medical Ethics and Medical Law a Symbiotic Relationship* p. 69.

²⁹⁰ See for example, *Bolitho v City and Hackney Health Authority* [1998] A.C. 232 and *Pearce v Untied Bristol Healthcare NHS trust* [1999] E.C.C. 167.

²⁹¹ *Smith v Tunbridge Wells HA* [1994] 5 Med LR 334.

²⁹² *Ibid.* p. 338.

²⁹³ J Miola *Medical Ethics and Medical Law a Symbiotic Relationship* p. 70-71.

²⁹⁴ S Pattinson *Medical Law and Ethics* p. 130.

²⁹⁵ *Smith v Tunbridge Wells HA* [1994] 5 Med LR 334 p. 339.

²⁹⁶ J Mason and G Laurie *Mason and McCall Smith's Law and Medical Ethics* p. 125.

²⁹⁷ J Montgomery *Health Care Law* p. 247.

perceives....will be understood by the patient so that the patient can make an informed decision as to whether or not to consent to the recommended surgery or treatment.’²⁹⁸

It has been suggested that this approach would place a huge burden on doctors to find out if the patient has understood what he/she has been told.²⁹⁹ On the other hand, it has been said that it is axiomatic that just providing the patient with information is not sufficient; the patient must also be able to understand it and doctors must take this into consideration.³⁰⁰

Clearly, ensuring that the information that has been provided is in fact completely understood is difficult.³⁰¹ I would agree with McLean that although we assume that understanding is vital for the legal validity of the patient’s decision, ‘it is less than clear how we can either ensure it, or even identify its presence or absence.’³⁰² Faden and Beauchamp suggest that demonstrating that the patient has understood the provided information ‘may ultimately depend both on the adequacy of the person’s understanding of disclosed information and on the adequacy of the professional’s grasp of the person’s questions and responses.’³⁰³ I would agree with McLean’s response that patient understanding and professional skill in assessing this as endorsed by Faden and Beauchamp is ‘desirable’, but that would be difficult to be translated into a legal principle, as assessing the authenticity of the person’s understanding would not be ‘straightforward.’³⁰⁴

The duty to take reasonable care to ensure the patient has understood the information was discussed further in *AlHamwi v Johnston*.³⁰⁵ This case drew a distinction between a legal duty to take reasonable steps to seek to ensure that a patient has understood information and a legal duty to take reasonable steps to seek to ensure that a patient can understand. *AlHamwi*’s lawyer argued that the clinic’s duty of care included the duty to ensure that the information that had been given to the patient was understood by her. The case was dismissed, Simon J holding that doctors have no obligation to ensure that patients have understood the information that has been given to them.³⁰⁶ In his view this would place a heavy burden on them and ‘[i]t is difficult to see what steps could be devised to ensure that

²⁹⁸ *Smith v Tunbridge Wells HA* [1994] 5 Med LR 334 p. 339.

²⁹⁹ *M Jones Medical Negligence* para 7.036-7.038 p. 678-679.

³⁰⁰ M Mayberry and J Mayberry ‘Consent with Understanding: A Movement towards Informed Decisions’ (2002) 2(6) *Clin Med JRCPL* 523–526 p. 524-525.

³⁰¹ J Hutton and R Ashcroft ‘Some Popular Versions of Uninformed Consent’ p. 45.

³⁰² S McLean *Autonomy, Consent and the Law*. p. 50.

³⁰³ R Faden and T Beauchamp *A History and Theory of Informed Consent*. p. 316.

³⁰⁴ S McLean *Autonomy, Consent and the Law* p. 50.

³⁰⁵ *AlHamwi v Johnston* [2005] EWHC 206 (QB).

³⁰⁶ *Ibid.* para 69 and E Jackson *Medical Law Text, Cases and Materials* p.190.

a patient has understood, short of a vigorous and inappropriate cross-examination’.³⁰⁷ I would agree with Simon J’s suggestion that ‘[c]linicians should take reasonable and appropriate steps to satisfy themselves that the patient has understood the information which has been provided.’³⁰⁸ For Simon J, giving the patient a leaflet which clearly contains the information can be sufficient to amount to taking reasonable steps.³⁰⁹

Nonetheless, the decision in *AlHamwi* has been criticised on the basis that such an approach does not sufficiently protect the patient’s autonomy, if a patient such as *AlHamwi* in fact misunderstands of the information.³¹⁰ Disclosing information with no requirement to ensure patient understanding may be viewed as meaningless. As has been stated in Chapter one, if providing information is vital to the patient’s ability to exercise autonomy, it would not be effective in achieving this unless it is understood.³¹¹ Thus, it has been said that the decision in *AlHamwi* failed to recognise this, as it seems to be more focused on the issue of providing information without emphasising the need for effective communication to ensure that the patient has understood the information.³¹² Arguably, if the aim of law in such matters is to protect patient autonomy, the decision in *AlHamwi* seems to marginalise the notion of doing so.³¹³

With all due respect to the views of those who considered that the decision in *AlHamwi* undermined respect for the patient’s autonomy, I would argue that *AlHamwi* is another example where legal and ethical principles may differ. Ethical principles can be seen as ideals to be considered and would achieve the highest level of protecting the individual’s autonomy but those ideals may be difficult to translate into legal rules that can be fairly and effectively applied.³¹⁴ I would agree with Simon J’s comment that: ‘A patient may say she understands although she has not in fact done so, or has understood part of what has been said, or has a clear understanding of something other than what has been imparted.’³¹⁵ Hence, if the person him/herself may not know whether he/she has understood the provided information or not it would be even more difficult for another to be certain that the person has understood, especially since ‘[i]t is common experience that misunderstandings can arise

³⁰⁷ *Ibid.*

³⁰⁸ *Ibid.*

³⁰⁹ *Ibid.* para 54.

³¹⁰ J Coggon and J Miola ‘Autonomy, Liberty, and Medical Decision-Making’ p. 538.

³¹¹ N Waller ‘The Psychological Structure of Patient Autonomy’ p. 262.

³¹² J Miola ‘Autonomy Rued OK?’ (2006) 14 *Medical Law Review* 108–114 p. 112.

³¹³ *Ibid.* p. 113-144.

³¹⁴ For example, Lord Scarman’s argument in *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871.

³¹⁵ *Al Hamwi v Johnston* [2005] EWHC 206 (QB) para 69.

despite reasonable steps to avoid them.³¹⁶ This is a position which English law has now appeared to recognise by endorsing the doctors' legal duty to take reasonable steps to seek to ensure that patients can understand the information provided, which was affirmed in the subsequent case of *Montgomery* as I will discuss later on in this Chapter.

Despite the legal developments that have been discussed above, it can be said that these cases were still considered within the framework of the professional standard, albeit with different references to the various Law Lords' views in *Sidaway*. However, a particularly significant development in the proper interpretation of *Bolam* was the case of *Bolitho v City and Hackney Health Authority*.³¹⁷ The case was not concerned with information disclosure³¹⁸ but with an alleged negligent omission to treat.³¹⁹ Nonetheless, although in the case itself it was said not to be concerned with information disclosure, it has since been deemed to be applicable to such cases.³²⁰ *Bolitho* was described as 'a significant nail in *Bolam*'s coffin'.³²¹ It has been argued that in *Bolitho* Lord Browne-Wilkinson made it clear that the courts are to set what is to be considered reasonable care, not the medical profession.³²² In Lord Browne-Wilkinson's words, in relation to where there is a difference of opinion of medical expert witnesses as to whether the standard of care has been breached:

'...the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of the opinion that the defendant's treatment or diagnosis accorded with sound medical practice'.³²³

Clearly, Lord Browne-Wilkinson's argument is in favour of holding the courts' role to be in charge of critically analysing the medical experts' opinions to verify both the credibility of medical expert witnesses and whether their opinions are reasonable. This seems to take a similar approach to that of Morland J in *Smith* discussed previously. Therefore, even where there is a body of opinion by suitably qualified medical experts that what has been done is in accordance with the accepted practice, the defendant doctor can be held to have been negligent, as '...the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis'.³²⁴ For the court to override the

³¹⁶ *Ibid.*

³¹⁷ *Bolitho v City and Hackney Health Authority* [1998] A.C. 232.

³¹⁸ *Ibid.* p. 243. Per Lord Browne-Wilkinson.

³¹⁹ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p.172.

³²⁰ *Pearce v Untied Bristol Healthcare NHS trust* [1999] E.C.C. 167.

³²¹ J Mason and G Laurie *Mason and McCall Smith's Law and Medical Ethics* p. 149.

³²² M Brazier and J Miola 'Bye-Bye Bolam: A Medical Litigation Revolution?' (2000) 8 *Medical Law Review* 85-114 p. 85.

³²³ *Bolitho v City and Hackney Health Authority* [1998] A.C. 232 p. 241.

³²⁴ *Ibid.* p. 241-242.

views of expert witnesses that the approach adopted by the defendant was reasonable, it had to consider the following:

‘In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.’³²⁵

The court, therefore, added a condition to the *Bolam* test by requiring that the opinion on the defendant doctors’ action must be ‘capable of withstanding logical analysis’³²⁶ alongside the doctors’ action ‘being in accordance with responsible medical opinion’.³²⁷ Furthermore, according to the *Bolitho* amendment, the court may, after assessing whether the justification of the defendant’s medical opinion is based on logical analysis, judge this opinion against other expert views.³²⁸ Despite this, in *Bolitho* Lord Browne-Wilkinson recognised that it would be difficult for the court to reach a judgment that what medical experts concluded was acceptable practice was illogical. Thus, His Lordship emphasised that ‘in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable’.³²⁹ He justified this view because to assess and examine medical risks and benefits is ordinarily a matter of clinical judgement; therefore, judges may not have the knowledge and ability to make a finding on this without expert evidence. Therefore, ‘it is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant’s conduct falls to be assessed’.³³⁰

The amendment to the *Bolam* test by *Bolitho* still acknowledges the importance of medical expert evidence, as it is the primary basis for the court to make its judgment.³³¹ However, it has been argued that, in light of the *Bolitho* amendment, ‘it may no longer be sufficient for practitioner’s actions to be *Bolam*-defensible. The court would seek to determine whether such action is *Bolitho*-justifiable’.³³²

³²⁵ *Ibid.*

³²⁶ *Ibid.* p. 243.

³²⁷ E Jackson *Medical Law Text, Cases and Materials* p. 180.

³²⁸ H Teff ‘The Standard of Care in Medical Negligence – Moving on from *Bolam*?’ (1998) 14 *Oxford J Legal Studies* 473-484 p. 479-480.

³²⁹ *Bolitho v City and Hackney Health Authority* [1998] AC 232 p. 243.

³³⁰ *Ibid.*

³³¹ A MacLean ‘Beyond *Bolam* and *Bolitho*’ (2002) 5 *Medical Law International* (2002) 205-230 p. 212-213.

³³² A Samanta and J Samanta, ‘Legal Standard of Care: A Shift from the Traditional *Bolam*’. (2003) 3 *Clinic Med* 443-446 p. 446.

The effect of *Bolitho* can only be understood by examining the subsequent case law.³³³ The application of *Bolitho* can be seen from two angles in relation to information disclosure; first as a general matter, in the way medical expert's opinion is judged (whether it is *Bolitho* justifiable) and second the way that this duty has been seen to allow for a different approach to the standard of care in information disclosure. The *Bolitho* modification came to be applied to information disclosure as well as to diagnosis and treatment, where courts need to determine whether the non-disclosure of risks that has been approved by a body of medical opinion might nevertheless be considered as negligent.³³⁴ The scope for the courts to come to a different view of what was appropriate from those of medical professionals became an important matter to consider.

First, medical expert opinion: whether it is *Bolitho* justifiable

This significance of this issue can be seen in the case of *Marriott v West Midlands RHA*.³³⁵ Here, there were two conflicting bodies of medical opinion. Thus, the court had to make the decision on the basis of whether the medical expert's opinion had a logical support, (*Bolitho* justifiable).³³⁶ The judge in the trial had held that, although there was a body of medical expert opinion that supported the GP's action to leave the patient at his home, it was not a 'reasonably prudent course.'³³⁷ The decision was in favour of the patient and the decision was upheld at the appeal.³³⁸

However, where there are a number of responsible and prudent courses of action, Lord Scarman in *Maynard v West Midlands RHA*³³⁹ made the important point that:

'...that a judge's preference for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose opinions, truthfully expressed, honestly held, were not preferred...For in the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another.'³⁴⁰

³³³ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 173. See also A MacLean 'Beyond Bolam and Bolitho.' Here MacLean conducted a survey of post-*Bolitho* case law.

³³⁴ A Grubb *et al. Principles of Medical Law* para 4.06 p. 196-197.

³³⁵ *Marriott v West Midlands RHA* [1999] Lloyd's Rep. Med. 23.

³³⁶ A MacLean 'Beyond Bolam and Bolitho' p. 212-213.

³³⁷ *Marriott v West Midlands RHA* [1999] Lloyd's Rep. Med. 23. See also *Burne v A* [2006] EWCA Civ 24.

³³⁸ E Jackson *Medical Law Text, Cases and Materials* p. 117.

³³⁹ *Maynard v West Midlands Regional Health Authority* [1984] 1 W.L.R. 634.

³⁴⁰ *Ibid.* p. 693.

Arguably, the above statement seems to focus on the courts role in examining the credibility of witnesses instead of the content of their evidence,³⁴¹ allowing doctors to easily escape liability so long as they found one or more respectable expert witnesses that are ready to affirm that the doctor's action was in accordance with respected medical opinion.³⁴² To some extent, the approach in *Maynard* seems to be comparable to Islamic *Sharia* and Saudi Arabian medical law with its concentration on examining the credibility of witnesses rather than the reasonableness of the views they put forward, as will be discussed in Chapter four.

This movement by English courts³⁴³ has also been reflected in the issue of information disclosure, despite some inconsistency in approach. The trend towards greater court involvement in assessing medical evidence, not just the credibility of witnesses, is especially important in information disclosure cases because these are concerned with respecting the autonomy of patients, which is less of a matter of medical expertise than methods of diagnosis and treatment, as it rests on the information needs of patients.

Second, information disclosure: the application of the *Bolitho* modification to this aspect of medical care.

The reassessment of the professional standard seemed to continue in subsequent case law³⁴⁴ as further support was given to *Bolitho* by its application to information disclosure in *Pearce v United Bristol Healthcare NHS Trust*.³⁴⁵ In this case, the issue of the doctor's duty to warn about the risk of a stillbirth was the crux of the matter.³⁴⁶ The doctor had explained to the patient certain risks of both procedures, but failed to tell her that there was a 0.1% to 0.2% risk of a stillbirth. The woman agreed with the advice not to have a Caesarean section but her baby then died in the womb. The case was dismissed by the Court of Appeal.³⁴⁷

There are three interesting issues in *Pearce* that are worth mentioning: first, Lord Woolf MR in *Pearce* 'had no doubts that *Bolitho* applied to claims concerning information disclosure...'³⁴⁸ He held that a decision not to disclose information should be reasonable and

³⁴¹E Jackson *Medical Law Text, Cases and Materials* p. 114.

³⁴²For example, *De Freitas v O'Brien* [1995] P.I.Q.R. P281.

³⁴³See other cases which follow the same approach; *Reynolds v North Tyneside HA* [2002] Lloyd's Rep. Med. 459, *Penney & Ors v East Kent HA* [2000] P.N.L.R. 323 and *Smith v Southampton University Hospital NHS Trust* [2007] EWCA Civ 387.

³⁴⁴L Edozien *Self-Determination in Health Care A Property Approach to the Protection of Patients' Rights* p. 82.

³⁴⁵*Pearce v Untied Bristol Healthcare NHS Trust* [1999] E.C.C. 167.

³⁴⁶A MacLean 'From Sidaway to Pearce and Beyond: Is the Legal Regulation of Consent any Better Following a Quarter of a Century of Judicial Scrutiny?' (2012) 22 *Medical Law Review* 108–129 p. 117.

³⁴⁷*Pearce v Untied Bristol Healthcare NHS Trust* [1999] E.C.C. 167.

³⁴⁸M Brazier and J Miola 'Bye-Bye Bolam: A Medical Litigation Revolution?' p. 109.

responsible.³⁴⁹ Hence, Lord Browne-Wilkinson's view in *Bolitho* is applicable in matters of information disclosure.

Second, the discussion in *Pearce* supported Lord Bridge's approach in *Sidaway*, as Lord Woolf MR acknowledged that providing information might not only be a matter for professional judgement.³⁵⁰ Lord Woolf MR's referred to Lord Bridge's suggestion concerning the degree and severity of risk that ought to be disclosed, irrespective of the existence of a body of medical opinion on behalf of the defendant.³⁵¹ It will be remembered that Lord Bridge had given the example of a 10% risk of stroke as being such a risk. Lord Woolf MR formulated his view as follows:

'If there is a *significant risk* which would affect the judgment of a *reasonable patient*, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt.'³⁵² (Emphasis added).

However, it has been argued that Lord Woolf MR seemed '...to reject any reliance on 'precise percentages' and he re-interpreted Lord Bridge's approach'.³⁵³ This argument seems defensible, because His Lordship did not provide a clear explanation of what he meant by 'significant risk'.³⁵⁴ His Lordship considered that when the doctor seeks to provide the patient with information about risks the doctor '...has to take into account... the ability of the patient to comprehend what he has to say to him or her.'³⁵⁵ Despite this, 'where there is what can realistically be called a significant risk'³⁵⁶ Lord Woolf MR held that '...in the ordinary event,...the patient is entitled to be informed of that risk'.³⁵⁷ That risk must be one that a 'reasonable patient' would regard as relevant to make his or her decision.³⁵⁸

In applying his formulation of a relevant 'significant risk' to a 'reasonable patient', Lord Woolf MR argued that the 'very, very small additional risk of stillbirth [0.1% to 0.2%]'³⁵⁹

³⁴⁹ *Pearce v Untied Bristol Healthcare NHS Trust* [1999] E.C.C. 167 para 20.

³⁵⁰ *Ibid.* para 21.

³⁵¹ *Ibid.* para 22.

³⁵² *Ibid.* para 21.

³⁵³ A MacLean 'From Sidaway to Pearce and Beyond: Is the Legal Regulation of Consent any Better Following a Quarter of a Century of Judicial Scrutiny?' p. 117-118.

³⁵⁴ Kennedy and A Grubb *Medical Law* p. 709.

³⁵⁵ *Pearce v Untied Bristol Healthcare NHS Trust* [1999] E.C.C. 167 para 23.

³⁵⁶ *Ibid.*

³⁵⁷ *Ibid.*

³⁵⁸ *Ibid.* para 21.

³⁵⁹ *Ibid.* para 25.

was not a 'significant risk' that ought to have been disclosed.³⁶⁰ In addition His Lordship accepted the expert evidence on behalf of the defendants that 'the baby was not large, which would also mean that the risk would be reduced'.³⁶¹ Therefore, His Lordship concluded that '[t]his is a case where, in my judgment, it would not be proper for the courts to interfere with the clinical opinion of the expert medical man responsible for treating Mrs Pearce'.³⁶²

Nonetheless, Mason and Brodie observed that: 'For the first time, therefore, Lord Woolf introduced the reasonable patient standard of information disclosure as an acceptable part of English medical jurisprudence, and we suggest that this has been of considerable importance.'³⁶³ It has been argued that the judgment in *Pearce* was not 'wholly consistent or coherent and leaves the standard open to divergent interpretations'.³⁶⁴ Jackson, for example, contended that Lord Woolf MR's judgment has some 'ambiguity'.³⁶⁵ On one hand, Lord Woolf MR recognised the idea that a significant risk which would affect a 'reasonable patient' should be disclosed.³⁶⁶ That would seem to enhance the prioritisation of a prudent patient test. On the other hand, Lord Woolf MR relied on doctors' opinions to verify whether a risk should be regarded as significant. His Lordship stated that 'turning to the facts of this case, the next question is, therefore, [w]as there a significant risk? ...Even looked at comprehensively it comes to something like 0.1 to 0.2 per cent. The doctors called on behalf of the defendants did not regard that risk as significant, nor do I'.³⁶⁷

In other words, it appears that Lord Woolf MR combined the standards of both the reasonable doctor and reasonable patient. McLean argued that, even if the *Bolam* test may have been weakened by the judgment in *Pearce*, it was not straightforward to draw conclusions about its significance. She has said that '*Pearce* might seem to add an additional caveat to the routine acceptance of the *Bolam* test, namely the need to disclose risks that are 'significant' to the patients, its actual impact is not clear.'³⁶⁸ She went on to say that: 'It does, however, entail some consideration of the patient's interests, which the *Bolam* test does not do.'³⁶⁹ MacLean perhaps expressed slightly more optimism about the potential impact of *Pearce*:

³⁶⁰ M Brazier and J Miola 'Bye-Bye Bolam: A Medical Litigation Revolution?' p. 109.

³⁶¹ *Pearce v Untied Bristol Healthcare NHS Trust* [1999] E.C.C. 167 para 25.

³⁶² *Ibid.*

³⁶³ K Mason and D Brodie 'Bolam, Bolam - Wherefore Art Thou Bolam' (2005) 9(2) *Edinburgh Law Review* 298-306 p. 301.

³⁶⁴ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 176.

³⁶⁵ E Jackson *Medical Law Text, Cases and Materials* p. 181.

³⁶⁶ *Pearce v Untied Bristol Healthcare NHS Trust* [1999] E.C.C. 167 para 21.

³⁶⁷ *Ibid.* para 24.

³⁶⁸ S MacLean *Autonomy, Consent and the Law* p. 80.

³⁶⁹ *Ibid.*

‘[i]n theory it has inched towards a standard marginally more respectful of patient autonomy than *Bolam simpliciter*.’³⁷⁰ (His emphasis). Further, notwithstanding that the *Pearce* case was decided in favour of the defendant (the doctor), Miola also concluded that there was cause for optimism for patients as he argued that ‘Lord Woolf identified the principle of self-determination then, in upholding it, sought to protect the patient from the medical profession’.³⁷¹

Third, although Lord Woolf MR did not refer to Lord Bridge’s view in *Sidaway* that doctors must respond truthfully and fully to patients’ questions, His Lordship said that ‘...it is clear that if a patient asks a doctor about the risk, then the doctor is required to give an honest answer.’³⁷² This principle is supported by the view taken in *Montgomery* where the duty of answering the patient’s question has been acknowledged as will be turned to shortly.

Lord Woolf MR’s view in *Pearce* regarding the duty to inform the patient was interpreted further in *Wyatt v Curtis*.³⁷³ Sedley LJ held that Lord Woolf MR’s formulation in *Pearce* refined Lord Bridge’s view in *Sidaway*.³⁷⁴ Accordingly, a risk that might not be significant to doctors might be relevant to the patient; hence doctors should disclose that risk.³⁷⁵ This judgement can be said to be a further refinement of the applicable test in English law as it reinforces the position that doctors and patients may differ in their assessment of risk, with the ultimate decision as to its importance and/or relevance resting with the patient and not the clinician.

Based on what has been so far discussed above, it is clear since the decision was handed down in *Sidaway* in 1985 the English courts have interpreted the standard of care in information disclosure in a number of different ways. However, it is contended that there has been a clear movement away from the acceptance of a professional standard relying on what reasonable doctors would disclose toward greater acknowledgment of respecting patient autonomy through the development of a more patient-centred standard.

³⁷⁰ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 176.

³⁷¹ J Miola *Medical Ethics and Medical Law a Symbiotic Relationship* p. 72.

³⁷² *Pearce v Untied Bristol Healthcare NHS Trust* [1999] E.C.C. 167 para 5.

³⁷³ *Wyatt v Curtis* [2003] EWCA Civ 1779.

³⁷⁴ J Samanta and A Samanta *Medical Law* (Palgrave Macmillan 2011) p. 147.

³⁷⁵ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 177.

4.2. *Chester* and beyond

*Chester v Afshar*³⁷⁶ has added a further development to the standard of care in information disclosure in English law. The *Chester* case is significant also in respect of the issue of causation,³⁷⁷ which will be returned to in more detail later in this Chapter. Chester was suffering from back pain, so her doctor, Afshar, recommended that she have an operation to remove three spinal disks. Chester agreed to undergo the operation, but as a result of the operation she was partly paralysed due to nerve damage.³⁷⁸ Although the operation was conducted properly, the doctor failed to warn Chester of the 1% -2% risk of nerve damage.³⁷⁹ Chester claimed that, if she had been informed about the risks of the operation, she would not have consented to the operation immediately; rather, she would have sought other doctors' views.³⁸⁰ Both parties relied on expert medical evidence about what should have been disclosed as well as their own testimony.³⁸¹ Afshar claimed that he had adequately warned her about the risks and that even if this was not accepted, the claim should fail as she was not claiming that she would never have undertaken the operation. The case was finally decided by the House of Lords, which upheld the decision in favour of the claimant.

In her commentary on *Chester* Devaney, argued that 'the primary concern of the majority of the House of Lords...was to ensure that patient autonomy is respected.'³⁸² Indeed, respect for the patient's autonomy seems to play an essential role in Law Lords' views regarding both causation and information disclosure.³⁸³ The emphasis on recognising the ethical aspects of information disclosure in consent to treatment led the majority in *Chester* to consider what has been viewed as a shift in emphasis in the law of information disclosure,³⁸⁴ to apply the reasonable patient standard. For a minority of the court (Lords Bingham and Hoffman) *Chester* failed to establish causation. Nevertheless, both recognised that doctors have a duty to warn their patients and give them information regarding inherent risks in the treatment, Lord Bingham arguing that this is '...to enable adult patients of sound mind to make for themselves decisions intimately affecting their own lives and bodies'.³⁸⁵ Lord Hoffman also

³⁷⁶ *Chester v Afshar* [2004] UKHL 41.

³⁷⁷ *Ibid.* para 1 Per Lord Bingham.

³⁷⁸ *Chester v Afshar* [2004] UKHL 41.

³⁷⁹ *Ibid.*

³⁸⁰ *Ibid.*

³⁸¹ See the judgment in the High Court of Justice Queen's Bench Division, *Chester v Afshar* 2000 WL 33201379.

³⁸² S Devaney 'Autonomy Rules OK' (2005) 13(1) *Med Law Review*. 102-107 p. 107.

³⁸³ K Mason and D Brodie 'Bolam, Bolam - Wherefore Art Thou Bolam' p. 302

³⁸⁴ For example, C Foster 'Autonomy in the Medico-Legal Courtroom: A Principle Fit for Purpose?' (2014) 22(1) *Medical Law Review*, 48-63. and J Coggon and J Miola 'Autonomy, Liberty, and Medical Decision-Making'.

³⁸⁵ *Chester v Afshar* [2004] UKHL 41 para 5.

recognised that the failure to warn the patient about the risk ‘was an affront to her personality and leaves her feeling aggrieved.’³⁸⁶

Lord Bingham held that Afshar was under a duty to warn and inform Chester ‘...of a small (1%-2%) but unavoidable risk that the proposed operation, however expertly performed, might lead to a seriously adverse result,...The existence of such a duty [to warn] is not in doubt.’³⁸⁷ In fact this acknowledgment by Lord Bingham of doctors’ duty to warn the patient about small risks was no surprise as His Lordship had affirmed that: ‘The patient’s right to be appropriately warned is an important right, which few doctors in the current legal and social climate would consciously or deliberately violate’.³⁸⁸

Lord Steyn (who was in the majority) emphasised that ‘...a patient’s right to an appropriate warning from a surgeon when faced with surgery ought normatively to be regarded as an important right which must be given effective protection whenever possible’.³⁸⁹ The importance of the case can be understood from Lord Steyn’s speech. He approved Lord Woolf MR’s reformation and interpretation of *Sidaway’s* (Lord Bridge’s) disclosure principle in *Pearce*.³⁹⁰ However, he went on to state that ‘[i]n modern law medical paternalism no longer rules and a patient has a prima face right to be informed by a surgeon of a small, but well established, risk of serious injury as a result of the surgery’.³⁹¹ He also separately referred to the need to warn about ‘serious risks’.³⁹² Meyers argued that Lord Steyn (with Lords Hope’s and Walker’s agreement) has moved the English law standard to disclose risks from the professional standard (*Bolam* test) of care to a reasonable patient standard.³⁹³

However, despite Lord Steyn’s clear emphasis on respect for the patient’s autonomy being the basis for His Lordship’s decision, it has been said that the decision in *Chester* is ‘startling’ in the ‘lack of clarity’ regarding what is meant by serious risks.³⁹⁴ This is because the reference to the term ‘serious risks’ may have two different interpretations: either ‘any risks of serious consequences, or significant risks (in the sense of the risk being high in percentage

³⁸⁶ *Ibid.* para 33.

³⁸⁷ *Ibid.* para 5.

³⁸⁸ *Ibid.* para 9

³⁸⁹ *Ibid.* para 17.

³⁹⁰ E Jackson *Medical Law Text, Cases and Materials* p. 182.

³⁹¹ *Chester v Afshar* [2004] UKHL 41 para 16.

³⁹² *Ibid.*

³⁹³ D Meyers ‘*Chester v. Afshar: Sayonara, Sub Silentio, Sidaway?*’ in S McLean (ed.) *First Do No Harm: Law, Ethics and Healthcare* (Ashgate 2006) 254-271 p. 264.

³⁹⁴ K Wheat ‘Progress of the Prudent Patient: Consent After *Chester v Afshar*’ (2005) 60(3) *Anaesthesia* 215-219 p. 218.

terms) of any undesired, but nevertheless minor, consequences’.³⁹⁵ Even more importantly, there was a further lack of clarity because Lord Steyn did not state whether the seriousness of the risks would be judged based on a patient’s view or a doctor’s view. In this regard, I would agree with what Jackson suggested: because Lord Steyn obviously stated his rejection of the rule of paternalism, this would suggest the result of his view is to test ‘serious risks’ based on the reasonable patient standard.³⁹⁶

Lord Hope also recognised that ‘[i]t was not in dispute’³⁹⁷ that the patient should be informed and warned about the known and small risk of nerve damage. His Lordship believed that the reason for considering such a duty to warn the patient arose because ‘the right to make the final decision and the duty of the doctor to inform the patient if the treatment may have special disadvantages or dangers go hand in hand.’³⁹⁸ Therefore, Afshar owed a duty to warn Chester about ‘the risks that were inherent in the proposed surgery, including the risk of paralysis.’³⁹⁹ Lord Hope emphasised that the duty to inform is important to ensure that the patient can make the final decision either to consent to or not to undergo the operation that was proposed.⁴⁰⁰ The issue of respect for patient autonomy was considered further in Lord Walker’s judgment. His Lordship first asserted that ‘[t]he surgeon’s duty to advise his patient (and in particular, to warn of unavoidable risks of surgery) is a very important part of his professional duty.’⁴⁰¹ His Lordship seems to distance himself from *Sidaway* and the professional standard of care. Lord Walker affirmed that ‘...during the 20 years which have elapsed since *Sidaway*’s case the importance of personal autonomy has been more and more widely recognised.’⁴⁰² The stance taken in *Chester* appears to abandon the majority views in *Sidaway* (professional standard) by acknowledging the reasonable patient standard. *Chester* has ‘marginalised’ the majority’s decision in *Sidaway* and endorsed/moved on the reasonable patient standard that *Pearce* had approved.⁴⁰³

Lord Walker in regard to the duty of informing and disclosing the risk to patients has stated that: ‘The surgeon’s duty to advise and warn his patient is closely connected with the need for the patient’s consent...The advice is the foundation of the consent. That is why it is so

³⁹⁵ Ibid.

³⁹⁶ E Jackson *Medical Law Text, Cases and Materials* p. 182.

³⁹⁷ *Chester v Afshar* [2004] UKHL 41 para 48.

³⁹⁸ Ibid. para 55.

³⁹⁹ Ibid.

⁴⁰⁰ Ibid.

⁴⁰¹ Ibid. para 92.

⁴⁰² Ibid. para 92.

⁴⁰³ D Meyers ‘*Chester v. Afshar: Sayonara, Sub Silentio, Sidaway?*’ p. 265.

important.⁴⁰⁴ However, it should be noted that the concept of therapeutic privilege also remains, as the court held that '[t]he only qualification [to not warn] is that there may be wholly exceptional cases where objectively in the best interests of the patient the surgeon may be excused from giving a warning.'⁴⁰⁵ Thus, as it was accepted in *Pearce*, there are some exceptional circumstances that may justify doctors withholding information from patients, although it would ultimately be for the court to decide whether the law should hold that the information should have been provided.⁴⁰⁶

Due to the significance of *Chester* with regard to the change of the standard of information disclosure and doctors' duty to disclose risks by adopting the standard in *Pearce* I would agree with Meyers's conclusion that

'it may be that *Chester* will prove to be more noteworthy for defining the scope of the doctor's duty to warn his or her patient of the risks inherent or special in the treatment being proposed... *No longer can the reasonable doctor standard of Bolam, as applied in the disclosure of risk context by Sidaway, be said to be the law.*'⁴⁰⁷ (Emphasis added).

In fact, this recognition of the reasonable patient standard of care seems to be clearly held and supported in the recent decision in *Montgomery* but before turning to that decision it is worth considering two other significant cases: *Birch v UCL Hospital*⁴⁰⁸ and *Jones v North West SHA*.⁴⁰⁹ In these cases, the issue of the doctors' duty to inform the patient about alternative available treatment(s) was considered. This approach is recognised by *Montgomery* as the thesis will discuss in a moment.

Birch was the first English law case which discussed the doctor's duty to provide the patient with information regarding alternative treatments.⁴¹⁰ Cranston J relied on both *Pearce* and *Chester* in reaching his judgment, he recognised that: 'If patients must be informed of significant risks it is necessary to spell out what, in practice, that encompasses'.⁴¹¹ Cranston J then asked 'was it necessary for the defendant to go further and to inform Mrs Birch of comparative risk, how this risk [of cerebral catheter angiography] compared with that

⁴⁰⁴ *Chester v Afshar* [2004] UKHL 41 para 93.

⁴⁰⁵ *Ibid.* para 16. Per Lord Steyn.

⁴⁰⁶ K Hodgkinson 'The Need to Know—Therapeutic Privilege: A Way Forward' p. 112.

⁴⁰⁷ D Meyers '*Chester v. Afshar: Sayonara, Sub Silentio, Sidaway?*' p. 270.

⁴⁰⁸ *Birch v UCL Hospital* [2008] EWHC 2237 (QB).

⁴⁰⁹ *Jones v North West SHA* [2010] EWHC 178 (QB).

⁴¹⁰ R Heywood 'Medical Disclosure of Alternative Treatments' (2009) 68(1) *The Cambridge Law Journal* 30-32 p. 31

⁴¹¹ *Birch v UCL Hospital* [2008] EWHC 2237 (QB). para 74.

associated with other imaging procedures, in particular MRI?⁴¹² He answered that by rephrasing Lord Woolf MR's view in *Pearce* that '...unless the patient is informed of the comparative risks of different procedures she will not be in a position to give her fully informed consent to one procedure rather than another'.⁴¹³ It can be said that *Birch* has recognised a legal duty on doctors to not only inform the patient about the significant risks, but also inform him/her about the available alternative treatments. Thus the result of the decision in *Birch* is to endorse the reasonable patient standard and to take it a stage further in applying it to information about alternative treatments.⁴¹⁴

In the same way, the subsequent case of *Jones* has recognised the same legal duty as outlined in *Birch*.⁴¹⁵ Nicol J based on his reading of Lord Woolf MR's view in *Pearce*, stated that '[a]t least where there was a viable medical alternative to the natural route, the patient was entitled to be told of any significant risk that attached to either course.'⁴¹⁶ Arguably, Nicol J in his judgment seems to go beyond the professional standard of care as he concluded that: 'Whether or not a risk is 'significant' is ultimately for the Court to decide.'⁴¹⁷ This statement is a departure from the *Bolam* test, where the disclosure of risks was determined by prudent medical profession. It also goes further than the *Bolitho* modification, where the medical evidence can only be challenged if, in a rare case, it is not 'logical'. It even seems to go further than *Pearce*, by placing even less weight on whether the medical profession considers that a risk is 'significant'. This suggests that Nicol J's view is 'closer to the spirit of the prudent patient test than is evidenced in the way Lord Woolf applied the test in practice',⁴¹⁸ where greater reliance appeared to have been placed on whether doctors viewed the risk as significant or not.⁴¹⁹

In conclusion, in considering these cases, Jackson observed that 'while *Sidaway* itself has not been overruled, it seems clear that English law has been moving away from the strict application of *Bolam* adopted by Lord Diplock...towards a more patient-central approach'.⁴²⁰ McLean also has concluded that the test of English law regarding the

⁴¹² *Ibid.*

⁴¹³ *Ibid.*

⁴¹⁴ E Jackson *Medical Law Text, Cases and Materials* p. 182.

⁴¹⁵ J Mason and G Laurie *Mason and McCall Smith's Law and Medical Ethics* p. 128.

⁴¹⁶ *Jones v North West SHA* [2010] EWHC 178 (QB) para 24.

⁴¹⁷ *Ibid.*

⁴¹⁸ A MacLean 'From *Sidaway* to *Pearce* and Beyond: Is the Legal Regulation of Consent any Better Following a Quarter of a Century of Judicial Scrutiny?' p. 123.

⁴¹⁹ The case did not succeed. She failed on the element of causation and the case was ruled in favour of the doctors *Jones v North West SHA* [2010] EWHC 178 (QB) para 100

⁴²⁰ E Jackson *Medical Law Text, Cases and Materials* p. 183.

information disclosure standard seems to have moved away from a prudent doctor standard to a prudent patient standard with the doctor's duty to disclose information emerging from the patient's right to respect for autonomy.⁴²¹ Hoppe and Miola have taken this view too and stated that the courts since *Chester* had 'prioritised' the principle of respect for autonomy which allowed them to redefine what is meant by a significant risk.⁴²²

Nonetheless, before the decision of the UK Supreme Court in *Montgomery* it was still unclear whether English law would unequivocally adopt a 'prudent patient' rather than 'prudent doctor' standard for information disclosure.⁴²³ I would also agree with MacLean that, as long as the question of how to decide what is meant by a significant risk had not been fully addressed by the law, the standard of care for information disclosure in English law would remain uncertain.⁴²⁴ It can be argued that this confusion has been now cleared up by the recent decision of the UK Supreme Court in *Montgomery* as will be discussed in the following section.

4.3. *Montgomery*, a new dawn?

4.3.1. The case facts and legal background

On 1 October 1999, Montgomery gave birth by vaginal delivery to a baby boy. Due to a complication during her delivery, shoulder dystocia, the baby was born with severe disabilities. Montgomery was a diabetic and therefore more likely to have a larger baby and there was a 9-10% risk of shoulder dystocia during vaginal delivery, because the baby's shoulders cannot easily pass through the mother's pelvis. Montgomery brought a claim in negligence for damages on behalf of her child. She argued that (1) although she had expressed her concern to the doctor about whether she could safely deliver the baby vaginally, Dr. McLellan had failed to inform her about the risk (9-10%) of severe damage from shoulder dystocia and (2) she had had not been offered the optional Caesarean section, which would have prevented the damage to the baby.⁴²⁵

The case was first heard in Scotland, by Lord Bannatyne (the Lord Ordinary) in the Outer House of the Court of Session.⁴²⁶ The Lord Ordinary first applied the principle that was set

⁴²¹S MacLean *Autonomy, Consent and the Law* p. 82.

⁴²²N Hoppe and J Miola *Medical Law and Medical Ethics* (1sted CUP 2014) p. 88.

⁴²³E Jackson *Medical Law Text, Cases and Materials* p. 183-184.

⁴²⁴A MacLean 'From Sidaway to Pearce and Beyond: Is the Legal Regulation of Consent any Better Following a Quarter of a Century of Judicial Scrutiny?' p. 125-126.

⁴²⁵*Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

⁴²⁶*Montgomery v Lanarkshire Health Board* [2010] CSOH 104.

out in the *Bolitho* modification to examine whether the medical evidence that supported the defender had been reached on a logical basis.⁴²⁷ His Lordship, in considering the defendant's medical evidence, argued that: 'It could not be said that their views on the interpretation lacked reasoning, rationality or logic.'⁴²⁸ Thus, for the Lord Ordinary the case could not be one of the rare cases where the judge was entitled to reject a body of expert evidence that was supporting the doctor's action.⁴²⁹ Accordingly, His Lordship stated 'in those circumstances, it cannot be established that there was a failure in the care at this point by Dr McLellan not intervening.'⁴³⁰

He then went on to apply the principle of Lord Bridge in *Sidaway* that it was necessary to inform the patient about 'a substantial risk of grave consequences'⁴³¹ and in *Pearce* that it was necessary to inform of 'a substantial risk which would affect the judgement of a reasonable person.'⁴³² For the Lord Ordinary the risk of shoulder dystocia was significant, but that did not require the doctor to warn the patient because 'in the vast majority of shoulder dystocia cases the shoulder dystocia was dealt with by *simple procedures and the chance of a severe injury to the baby was tiny*.'⁴³³ (Emphasis added). In other words, the risk of shoulder dystocia occurring was high, but the risk of a severe injury was not. His Lordship therefore concluded that this did not meet the requirements of a substantial risk of grave consequences.⁴³⁴ The decision to withhold this information therefore withstood logical analysis and thus Montgomery failed to establish that there was a breach of the duty to inform her about the risks, and as a result the Lord Ordinary dismissed the case.⁴³⁵

Montgomery's case was then heard by three judges in the Inner House of the Court of Session.⁴³⁶ The appellant argued that English law had moved on to require warnings to be given to the patient about a significant risk, as in *Pearce* by Lord Woolf and that Scottish law should also do so.⁴³⁷ Therefore, as the risk of shoulder dystocia was a significant risk, it

⁴²⁷R Heywood 'Commentary Negligent Antenatal Disclosure and Management of Labour Nadine Montgomery v Lanarkshire Health Board' (2011) *Medical Law Review* 1 -10 p. 3.

⁴²⁸*Montgomery v Lanarkshire Health Board* [2010] CSOH 104 para 205.

⁴²⁹*Ibid.* para 207.

⁴³⁰*Ibid.* para 215.

⁴³¹*Ibid.* para 227.

⁴³²*Ibid.*

⁴³³*Ibid.* The percentage was '1/500 approximately for a brachial plexus injury and of that 1/500 approximately 1–2% of those would suffer cerebral palsy.' para 229.

⁴³⁴*Montgomery v Lanarkshire Health Board* [2010] CSOH 104 para 234, 235 and 236.

⁴³⁵*Ibid.* para 269.

⁴³⁶*Montgomery v Lanarkshire Health Board* [2013] CSIH 3; 2013 S.C. 245.

⁴³⁷*Ibid.* para 13.

should attract the duty to inform. It was further contended that she should have been given advice about optional Caesarean section on the basis of *Jones*.⁴³⁸ It will be remembered that *Jones* had held that patients should be given information about available alternative treatment options and their comparative risks. The Inner House of the Court of Session on the same basis as the Outer House refused the reclaiming motion and upheld the Lord Ordinary's decision.⁴³⁹ The case then went to the UK Supreme Court, where the Supreme Court re-examined the application of the standard of care in respect of information disclosure. It also dealt with the issue of causation (which will be discussed at the end of this Chapter).

4.3.2. *Sidaway* set aside

The decision by the Supreme Court was taken unanimously to allow the patient's appeal. Lords Kerr and Reed provided the leading judgments with which Lady Hale, Lords Neuberger, Clarke, Wilson and Hodge agreed. Lady Hale also delivered a concurring judgment.⁴⁴⁰

The Supreme Court in *Montgomery* was 'invited to depart from the decision of the House of Lords in *Sidaway* and to re-consider the duty of a doctor towards a patient in relation to advice about treatment.'⁴⁴¹ The Supreme Court stated that '...the analysis of the law by the majority in *Sidaway* is unsatisfactory, in so far as it treated the doctor's duty to advise her patient of the risks of proposed treatment as falling within the scope of the *Bolam* test, subject to two qualifications of that general principle, neither of which is fundamentally consistent with that test.'⁴⁴² The Supreme Court held that:

'It is unsurprising that courts have found difficulty in the subsequent application of *Sidaway*, and that the courts in England and Wales have in reality departed from it; a position which was effectively endorsed, particularly by Lord Steyn, in *Chester v Afshar*. There is no reason to perpetuate the application of the *Bolam* test in this context any longer.'⁴⁴³ (Original emphases)

Based on the previous discussion of the development of the English law standard of care, I would argue that the Supreme Court's decision is correct in its view that the decision in *Sidaway* no longer represents the current approach in medical practice to patient centered

⁴³⁸ *Ibid.*

⁴³⁹ *Ibid.* para 67.

⁴⁴⁰ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

⁴⁴¹ *Ibid.* para 4.

⁴⁴² *Ibid.* para 86.

⁴⁴³ *Ibid.*

treatment. It is also correct in deciding to depart from the professional standard of care which, despite attempts in some cases to ameliorate its effects, failed to sufficiently respect patient autonomy and self-determination as well as representing a paternalistic approach which is no longer accepted in the medical context.⁴⁴⁴

McGrath has observed two reasons that led the Supreme Court to depart from the professional standard derived from *Sidaway*; first ‘*Sidaway* had been misunderstood in practice.’⁴⁴⁵ McGrath has argued that the Justices in the Supreme Court have re-read *Sidaway*, thus the Supreme Court ‘took Lord Scarman’s opinion as the ratio, reading Lords Bridge, Keith, and Templeman as joining him in placing the patient first.’⁴⁴⁶ Based on that, the Supreme Court stated that the decision in *Pearce* correctly interpreted Lord Bridge’s view in *Sidaway*.⁴⁴⁷ A substantial risk which it is necessary for the patient to know in order to make an informed choice should be disclosed.⁴⁴⁸ The second reason McGrath observed for the Supreme Court to depart from the professional standard in *Sidaway* is that, ‘the paternalistic model of the doctor–patient relationship on which it was based had ceased to reflect reality.’⁴⁴⁹ As the Supreme Court noted, since the decision in *Sidaway* was taken, there has been an obvious shift towards more recognition of the importance of respect for patients’ autonomy and the value of their self-determination.⁴⁵⁰ Therefore, it can be argued that the decision of the Supreme Court has effectively overruled *Sidaway*, though it did not expressly do so, and pronounced a new standard of care for the UK that more properly respects patient autonomy. This will be considered further below.

4.3.3. The prudent patient standard of care as the current approach to information disclosure in England

By allowing the appeal in *Montgomery*, the Supreme Court has now clearly accepted the patient prudent test into the law of consent in the UK.⁴⁵¹ The Supreme Court reached its decision on the matter by placing more emphasis on respect for patient self-determination and rights. As it was said, ‘...patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession.’⁴⁵² This shows that

⁴⁴⁴ For example, Lord Steyn view in *Chester v Afshar* [2004] UKHL 41 para 16.

⁴⁴⁵ C McGrath ‘Trust me, I’m a Patient’: Disclosure Standards and the Patient’s Right to Decide’ (2015)74(2) *The Cambridge Law Journal* 211-214 p. 212.

⁴⁴⁶ *Ibid.* p. 213.

⁴⁴⁷ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 69.

⁴⁴⁸ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 900.

⁴⁴⁹ C McGrath ‘Trust me, I’m a Patient’: Disclosure Standards and the Patient’s Right to Decide’ p. 213.

⁴⁵⁰ *Ibid.* p. 213.

⁴⁵¹ R Griffith ‘Duty to Warn of Risks Moves to a Prudent Patient Approach’ p. 408.

⁴⁵² *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 75.

the Supreme Court has departed from the approach of professional practice in setting an appropriate standard of care with its overtones of paternalism and considered the ethical issues of respecting and protecting patients' autonomy in the medical care context as taking priority.⁴⁵³ The Supreme Court's position shows, as Farrell and Brazier have observed, that the era of accepting that doctors know best about what information should be given to the patient is ended.⁴⁵⁴ The Supreme Court recognised that this is in part because now it is easier for the patient to gain medical information from a different variety of sources such as the internet, medicine labelling and so forth. Hence:

‘It would therefore be a mistake to view patients as uninformed, incapable of understanding medical matters, or wholly dependent upon a flow of information from doctors. The idea that patients were medically uninformed and incapable of understanding medical matters was always a questionable generalisation.....To make it the default assumption on which the law is to be based is now manifestly untenable.’⁴⁵⁵

This view advances the idea of not seeing the patients just as passive recipients of the information that doctors give to them. Instead the new understanding of medical practice and law is to recognise the idea of dealing with patients ‘...so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices.’⁴⁵⁶

Interestingly, what followed from that is that the Supreme Court confirmed that the patient can decide whether she wants to receive information about the risk or not, so if the patient has made that clear to the doctor, then there is no obligation on the doctor to discuss the risk.⁴⁵⁷ However, it was cautioned that the matter of ‘[d]eciding whether a person is so disinclined may involve the doctor making a judgment; but it is not a judgment which is dependent on medical expertise.’⁴⁵⁸ Here too, the doctor's obligation in deciding whether to discuss with the patient the risk or not is a matter of respecting patient autonomy and in the final analysis this would fall to be determined by the courts not the medical profession.⁴⁵⁹ It

⁴⁵³ J Miola ‘Making Decisions about Decision-Making: Conscience, Regulation and the Law’ (2015) 23(2) *Med Law Review* 263-282 p. 277.

⁴⁵⁴ A Farrell and M Brazier ‘Not So New Directions in the Law of Consent? Examining *Montgomery v Lanarkshire Health Board*’ (2016) 42 *J Med Ethics* 85-88 p.86.

⁴⁵⁵ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 76.

⁴⁵⁶ *Ibid.* para 81.

⁴⁵⁷ *Ibid.* para 85.

⁴⁵⁸ *Ibid.*

⁴⁵⁹ R Heywood ‘R.I.P. Sidaway: Patient-Oriented Disclosure —A Standard Worth Waiting for?’ (2015) 23(3) *Med Law Review* 455–466 p. 457.

remains the case, as the Supreme Court has affirmed, that: ‘An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken.’⁴⁶⁰

Based on these considerations and the recognition by the Supreme Court of the importance of respecting patient rights and autonomy, the Supreme Court outlined the appropriate standard of care as follows:

‘The doctor is therefore under a duty to take reasonable care to ensure that *the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.*’⁴⁶¹ (Emphasis added).

The question arises as to whether this is in fact simply a prudent patient test or whether it has gone some way toward a more subjective patient test. Noticeably, the Supreme Court has referred to testing the risks’ materiality against whether ‘the particular patient would be likely to attach significance to it.’⁴⁶² Heywood argues that the Supreme Court’s reference to the decision of the Australian High Court in *Rogers v Whitaker*,⁴⁶³ has introduced the *Rogers* approach into English law in *Montgomery*.⁴⁶⁴ In Heywood’s words, ‘[t]he test of materiality is no longer restricted just to what the reasonable person in the patient’s position would consider significant.’⁴⁶⁵ It will be remembered that Lord Scarman in *Sidaway* had adopted the *Canterbury* test:

‘The test of materiality is whether in the circumstances of the particular case *the court is satisfied that a reasonable person in the patient’s position would be likely to attach significance to the risk.*’⁴⁶⁶ (Emphasis added).

Instead the Supreme Court has stated that a material risk

‘...is whether, in the circumstances of the particular case, a reasonable person in the patient’s position would be likely to attach significance to the risk, *or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.*’⁴⁶⁷ (Emphasis added).

⁴⁶⁰ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 87.

⁴⁶¹ *Ibid.*

⁴⁶² *Ibid.*

⁴⁶³ *Rogers v Whitaker* [1992] HCA 58; (1992) 175 CLR 479.

⁴⁶⁴ R Heywood ‘R.I.P. Sidaway: Patient-Oriented Disclosure —A Standard Worth Waiting for?’ p. 460.

⁴⁶⁵ *Ibid.* p. 460.

⁴⁶⁶ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 889.

⁴⁶⁷ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 87.

Therefore, while the first part reflects exactly the *Canterbury* test, the second part is a new addition.

While the Supreme Court referred to ‘a reasonable person in the patient's position’, some concern has been expressed about what this means in practice. Reid has described this as an ‘..uncomfortable issue..’, left open as how this legal duty can be determined.⁴⁶⁸ The concern arises because the Supreme Court took notice of the fact that Montgomery was a ‘clearly highly intelligent person’,⁴⁶⁹ who obtained her degree in molecular biology and was a specialist in the pharmaceutical field; additionally, her mother and sister were both general medical practitioners.⁴⁷⁰

This may suggest that Montgomery had a higher than usual ability to understand the medical risks and might, by implication, be entitled to receive more information than others. If this is the case, then that would suggest the court may have two standards of a reasonable patient; one with high level of medical knowledge and the other with lower level of medical knowledge,⁴⁷¹ leaving uncomfortably open the question of how to define the ‘prudent patient’.⁴⁷²

The Supreme Court has recognised that ‘circumstances of an individual patient may affect their attitude towards a proposed form of treatment and the reasonable alternatives.’⁴⁷³ Heywood has argued that considering the position of the particular patient ‘is sensible and serves to underscore why it is so important for the law of negligence to include some reference to the individual patient.’⁴⁷⁴ He notes that in most cases there would be little difference in the outcomes; thus the specific inclusion of the particular patient, ‘could be regarded as superfluous.’⁴⁷⁵ It should also be noted that even where the particular patient would attach significance to the risk, when a reasonable person in the patient’s position would not, it is only required that the doctor disclose this information if the doctor *is or should reasonably be aware of this*.⁴⁷⁶ This additional test therefore is not an entirely subjective one since there is still a determination of reasonableness to be made.

⁴⁶⁸ E Reid ‘*Montgomery v Lanarkshire Health Board* and the Rights of the Reasonable Patient’ (2015) 19(3) *Edin LR* 360-366 p 364

⁴⁶⁹ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 6.

⁴⁷⁰ *Ibid.*

⁴⁷¹ E Reid ‘*Montgomery v Lanarkshire Health Board* and the Rights of the Reasonable Patient’ p. 364-365

⁴⁷² *Ibid.* p 365.

⁴⁷³ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 46.

⁴⁷⁴ R Heywood ‘R.I.P. Sidaway: Patient-Oriented Disclosure —A Standard Worth Waiting for?’ p. 460.

⁴⁷⁵ *Ibid.* p. 460.

⁴⁷⁶ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 87.

The Supreme Court also dismissed the use of a percentage test, as was suggested by Lord Bridge in *Sidaway*, to assess if the risk is material or not.⁴⁷⁷ The Supreme Court stated that whether a risk is deemed to be significant ‘...is likely to reflect a variety of factors besides its magnitude.’⁴⁷⁸ The Supreme Court then included some examples of what kinds of factors must be considered when evaluating whether there was a significant risk; ‘..the nature of the risk, the effect which its occurrence would have upon the life of the patient, the importance to the patient of the benefits sought to be achieved by the treatment, the alternatives available, and the risks involved in those alternatives.’⁴⁷⁹

Further, the use of the phrase ‘any reasonable alternative or variant treatments’⁴⁸⁰ by the Supreme Court suggests that it has accepted the approach taken in *Birch* that it is necessary to inform the patient about them. However, it has been said that the issue of how to identify when alternative treatments should be disclosed remains to be considered by subsequent case law because the Supreme Court has not set out further guidance on this.⁴⁸¹ Heywood has argued that the test of reasonableness of the doctors’ duty to disclose the alternative treatment would be considered in the light of the test of negligence as *Montgomery* suggests that ‘...negligence is still only a standard of reasonableness, and it would transcend that to expect doctors to disclose every conceivable course of action available.’⁴⁸² In this sense it will be difficult to consider doctors’ duty to be widely extended so as to disclose all possible alternatives, since these may not be available as viable treatment options and this might undermine ‘the effective provision of health care.’⁴⁸³ Furthermore, such an interpretation of the duty ‘would be destructive to the exercise of clinical discretion’, as it is still a vital element in the doctor–patient relationship, which may still be recognised even though the decision in *Montgomery* may marginalise it from the central place it formerly held.⁴⁸⁴

In the recent guidelines issued by the Royal College of Surgeons (RCS), which followed the principles outlined in *Montgomery*,⁴⁸⁵ doctors are subject to a general duty to provide the patient with information and ‘..ensure that the patient is provided with the information they need to make an informed decision about treatment. It may be appropriate, in order to

⁴⁷⁷ *Ibid.* para 89.

⁴⁷⁸ *Ibid.* para 87.

⁴⁷⁹ *Ibid.*

⁴⁸⁰ *Ibid.*

⁴⁸¹ C McGrath ‘Trust me, I’m a Patient’: Disclosure Standards and the Patient’s Right to Decide’ p. 214.

⁴⁸² R Heywood ‘R.I.P. Sidaway: Patient-Oriented Disclosure —A Standard Worth Waiting for?’ p. 464.

⁴⁸³ *Ibid.*

⁴⁸⁴ *Ibid.*

⁴⁸⁵ ‘Consent: Supported Decision-Making. A guide to Good Practice’ (2016) section 1.

facilitate discussion, to send information to the patient in advance.⁴⁸⁶ Further, the guidelines explain that: ‘In practice, this means that surgeons should provide information about:... Alternative options for treatment, including non-operative care and no treatment.... The material risks inherent in the procedure and in the alternative options discussed..⁴⁸⁷

It should be remembered that courts have the final say on how to discharge doctors from their duties. Thus I would agree with Heywood that it will be ‘fascinating...to see in the future whether or not litigation converges on this aspect of the duty and, if so, the parameters that judges will place on it in order to limit the legal exposure of doctors.’⁴⁸⁸

The test outlined in *Montgomery* interestingly retains something of the therapeutic exception, since it retained the possibility of allowing the doctor to withhold information in some, albeit rare, circumstances where disclosure would be ‘...seriously detrimental to the patient’s health.’⁴⁸⁹ The Supreme Court, however, clearly asserted that the ‘therapeutic exception should not be abused.’⁴⁹⁰ It has stated:

‘It is a limited exception to the general principle that the patient should make the decision whether to undergo a proposed course of treatment: it is not intended to subvert that principle by enabling the doctor to prevent the patient from making an informed choice where she is liable to make a choice which the doctor considers to be contrary to her best interests.’⁴⁹¹

Accordingly, the therapeutic exception should not be used in a way that unjustifiably interferes with patient autonomy, such as where the doctor simply fears that the patient will make an unwise choice. The Supreme Court dismissed the doctor’s submission in *Montgomery* that she chose to ‘withhold information about the risk of shoulder dystocia from her patients because they would otherwise request caesarean sections.’⁴⁹² The Supreme Court has responded that ‘the therapeutic exception is not intended to enable doctors to prevent their patients from taking an informed decision.’⁴⁹³ Therefore, ‘...it is the doctor’s responsibility to explain to her patient why she considers that one of the available treatment

⁴⁸⁶ *Ibid.* section 4(1).

⁴⁸⁷ *Ibid.*

⁴⁸⁸ R Heywood ‘R.I.P. Sidaway: Patient-Oriented Disclosure —A Standard Worth Waiting for?’ p. 464.

⁴⁸⁹ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 88.

⁴⁹⁰ *Ibid.* para 91.

⁴⁹¹ *Ibid.*

⁴⁹² *Ibid.* para 95.

⁴⁹³ *Ibid.*

options is medically preferable to the others, having taken care to ensure that her patient is aware of the considerations for and against each of them.⁴⁹⁴

I would argue that *Montgomery* can be used to contend that the professional/prudent doctor standard of providing patients with information is no longer the position to be taken by the law of the UK.⁴⁹⁵ Further, I would argue that English law (in the first part of *Montgomery* test) now provides a legal test that is able, to a large extent, to satisfy the ethical standard proposed in this thesis.

Based on *Montgomery* I would argue that the first criterion, that of the sufficiency of information disclosure, can be adequately achieved by applying the test adopted in *Montgomery* of whether a reasonable person in the patient's position would be likely to attach significance to the risk. The choice whether to consent to treatment or which option from those available to choose, remains with the competent adult patient regardless of the doctor's views on whether it is one which is in the patient's best interests. The means of safeguarding this choice is ordinarily to provide the patient with information on material risks and viable alternative treatment options. This retreat from a professional standard has not been adopted by Saudi Arabian law and it is an area in which reform will be proposed to protect patient autonomy more appropriately.

The sufficiency of information disclosure can also be achieved by recognising doctors' duty to answer the patient's questions fully and truthfully. The Supreme Court in *Montgomery* quoted with approval Lord Bridge's view in *Sidaway* that the duty is to answer the patient's questions fully and truthfully.⁴⁹⁶ *Montgomery* has therefore reinforced the legal position on this point and shows respect for patients' autonomy. The law is thereby brought into line with GMC guidelines which recognise that doctors 'must answer patients' questions honestly and, as far as practicable, answer as fully as they wish.'⁴⁹⁷

The second criterion of the proposed ethical ideal is that information should be understandable. As noted above, the decision taken in *AlHamwi* seemed not to place a duty on doctors to ensure that the patient had understood the information that had been provided to him, but it placed a duty on doctors to take reasonable steps to seek to ensure that patients can understand the information. Such a conclusion seems to be supported by the Supreme

⁴⁹⁴ Ibid.

⁴⁹⁵ J Miola 'Making Decisions about Decision-Making: Conscience, Regulation and the Law' p. 277.

⁴⁹⁶ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 54.

⁴⁹⁷ 'Consent: Patients and Doctors Making Decisions Together' (2008) Section 12.

Court in *Montgomery*, as the Supreme Court has asserted that a ‘dialogue’ between the doctor and the patient is necessary ‘...to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives..’⁴⁹⁸ That has as its aim to ensure that the patient can ‘make an informed decision.’⁴⁹⁹ This statement seems to suggest that information must not just be given to the patient, but to emphasise its purpose in enabling the patient to come to a sufficiently informed decision. The doctor must enter into a dialogue with the patient as part of providing advice and information. The RCS guidelines consider the matter of how to communicate the information to the patient: ‘Surgeons and other members of the healthcare team must ensure that any information is suitable for the individual patient and takes into account any issues that may impair effective communication, such as patients’ eyesight or hearing, English-language ability and literacy levels.’⁵⁰⁰

This duty to provide understandable information ‘cannot be demonstrated simply with a signed consent form. It is submitted that this will also require information to be given in a timely fashion so that it can be properly digested.’⁵⁰¹ It was further said that ‘[t]he doctor’s duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form.’⁵⁰² The RCS guidelines state that doctors’ require ‘.....to take time to explore the patient’s values and wishes about their care and to have sufficient experience to fully understand the risks and benefits that are material to the patient.’⁵⁰³ That duty falls on the doctor in charge of the patient’s case, or in some cases ‘..with an experienced member of the surgical team who has the time and skill to gain sufficient understanding of the patient’s views and wishes.’⁵⁰⁴ Additionally that individual must have ‘...sufficient knowledge of the associated risks and complications, as well as any alternative treatments available for the patient’s condition.’⁵⁰⁵

⁴⁹⁸ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 90.

⁴⁹⁹ *Ibid.*

⁵⁰⁰ Consent: Supported Decision-Making. A guide to Good Practice’ (2016) section 4(5).

⁵⁰¹ C McGrath ‘Trust me, I’m a Patient’: Disclosure Standards and the Patient’s Right to Decide’ p. 214.

⁵⁰² *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 90.

⁵⁰³ Consent: Supported Decision-Making. A guide to Good Practice’ (2016) section 4(6).

⁵⁰⁴ *Ibid.*

⁵⁰⁵ *Ibid.*

The above recognition by the Supreme Court of the need for doctors to seek to ensure that patients can understand the provided information is vital. This point is reiterated in the RCS guidelines which state:

‘Surgeons must be satisfied that their patient has received and understood sufficient information about their diagnosis – as well as the proposed treatment and its implications – to allow them to make a decision they deem to be in line with their own values and wishes. Different options for treatment, including the option of no treatment, should be presented side by side and the benefits and material risks should be given objectively.’⁵⁰⁶

Despite the Supreme Court’s emphasis on the issue of understanding and the importance of communicating with the patient, Heywood has argued that ‘the judgment stopped short of providing examples of precisely what a doctor will be expected to do in order to discharge her duty in this regard.’⁵⁰⁷ Heywood has expressed concern because the concept of ‘understanding’ is ‘fluid’ and it would be naturally different among patients.⁵⁰⁸ Thus, for Heywood

‘...this is surely the most curious and equivocal segment of the doctor’s duty. It is difficult for a doctor to gauge a patient’s understanding and equally challenging for a judge to articulate what reasonable steps have to be taken to ensure that there has been at least some attempt by the clinician to ascertain the level of patient comprehension.’⁵⁰⁹

I would agree with Heywood’s conclusion that the clarification of what approach doctors should take to explain and communicate risk to the patient will rely on how the decision in *Montgomery* is interpreted in subsequent case law.⁵¹⁰

What the judgment does seem to do is to move the law’s position closer to that outlined in the GMC guideline ‘Consent: Patients and Doctors Making Decisions Together’ which has advised doctors to:

‘...check whether the patient needs any additional support to understand information, to communicate their wishes, or to make a decision. You should bear in mind that some barriers to understanding and communication may not be obvious; for example, a patient may have unspoken anxieties, or may be affected by pain or other underlying problems. You must make sure, wherever practical, that arrangements are made to give the patient any necessary support. This might include, for example: using an advocate or interpreter; asking those close to the patient about the patient’s

⁵⁰⁶ Ibid. section 2(3) and section 4(4).

⁵⁰⁷ R Heywood ‘R.I.P. Sidaway: Patient-Oriented Disclosure —A Standard Worth Waiting for?’ p. 465.

⁵⁰⁸ Ibid.

⁵⁰⁹ Ibid.

⁵¹⁰ IR Heywood ‘R.I.P. Sidaway: Patient-Oriented Disclosure —A Standard Worth Waiting for?’ p. 465.

communication needs; or giving the patient a written or audio record of the discussion and any decisions that were made.⁵¹¹

In conclusion, I would agree with Heywood that '[i]t is not just the language of rights that has changed over time. It is also the substance of those rights, the importance that is attached to them, and, critically, what the law should demand of doctors to ensure that those rights are being adequately protected.'⁵¹² The Supreme Court has now affirmed that: 'Responsibility for determining the nature and extent of a person's rights rests with the courts, not with the medical professions.'⁵¹³ Therefore, the decision in *Montgomery* arguably has recognised the need to protect patients' autonomy and has gone further than ever before to shield patients' rights. In this sense, the age of paternalism has been rejected and patients are expected to be in charge of their decisions and choices. In other words, patient consent should be regarded as a process where patients are now the 'central figure.'⁵¹⁴

Thus, for the reasons I have above stated, although there remain issues to be resolved, I conclude that the development of the law culminating in *Montgomery* is capable of meeting the thesis's proposed ethical standard, as it can provide a legal basis for providing patients with sufficient and understandable information to respect their autonomy. As I have argued in Chapter two and for the reasons I have stated there and in the thesis Introduction, it is clear that there is no huge controversy for Islamic *Sharia* and Saudi Arabia to learn some lessons from other the legal systems. Thus, I will take forward the approach taken in *Montgomery* (the first part the prudent patient standard) in proposing reform to the current professional standard of care under Saudi Arabian medical law.

The above discussion of *Montgomery* shows how English law by adopting the prudent standard of care has dealt with issues that the current Saudi Arabian medical law has so far failed to adequately address. In Chapter four, I will demonstrate and explain these legal deficiencies and, in the Concluding Chapter, I will suggest proposals for reform based on that discussion.

So far, what has been discussed is the first two legal requirements to establish a negligence claim: (A) the duty of care and (B) a breach of that duty. It is also essential for a successful negligence claim that the patient can establish the third element: (C) causation. This is

⁵¹¹'Consent: Patients and Doctors Making Decisions Together' (2008) Section 21.

⁵¹²R Heywood 'R.I.P. Sidaway: Patient-Oriented Disclosure —A Standard Worth Waiting for?' P. 463.

⁵¹³*Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 83.

⁵¹⁴R Heywood 'R.I.P. Sidaway: Patient-Oriented Disclosure —A Standard Worth Waiting for?' p. 463.

another area where legal principles have made it difficult for patients to succeed in information disclosure cases. As the thesis focuses on the standard of care in information disclosure, the topic of causation will be addressed briefly, but with specific consideration of the issue of establishing causation in terms of information disclosure.

C. Causation

Kennedy and Grubb stated that ‘causation is the legal concept by which the defendant is held responsible for his conduct, which in this context means his negligence’.⁵¹⁵ The role of causation is to show the material connection between the defendants’ negligent action (or, more rarely, inaction) and the claimants’ damage.⁵¹⁶

Factual causation is the idea that the claimant must show a historical connection between the negligent action of the defendant and the injury or damage that happened.⁵¹⁷ The tool to establish that connection of causation is through the ‘but for’ test.⁵¹⁸ The ‘but for’ test was described by Lord Denning as follows:

‘[C]ausation is, I think, a question of fact. If you can say that the damage would not have happened but for a particular fault, then that fault is in fact a cause of the damage; but if you can say that the damage would have happened just the same, fault or no fault, then the fault is not a cause of the damage.’⁵¹⁹

The ‘but for’ test in action can be seen in the case of *Barnett v Chelsea and Kensington Hospital Management Committee*.⁵²⁰ Here three men in a hospital emergency department were asked to leave the hospital and see their own doctors by a nurse who received that instruction via a phone call from the doctor on duty. Barnett died later of arsenic poisoning and his widow sued the hospital for negligence.⁵²¹

The court held that neither hospital nor doctor were liable for the death. There had been no breach of the duty of care since even if the patient had been admitted to hospital there was no effective treatment and the claimant’s husband would still have died.⁵²² Hence, if the injury or damage would have happened regardless of the defendant’s negligence, negligence is not ‘causative of the claimant’s loss’.⁵²³ Based on the ‘but for’ test, in the case where the

⁵¹⁵ I Kennedy and A Grubb *Medical Law* p. 465.

⁵¹⁶ M Jones *Medical Negligence* para 5.002 p. 442.

⁵¹⁷ J Stapleton ‘Factual Causation’ (2010) 38(3) *Federal Law Review* 467-484.

⁵¹⁸ M Lunney and K Oliphant *Tort Law Text and Masteries* p. 210.

⁵¹⁹ *Cork v Kirby MacLean Ltd* [1952] 2 All E.R. 402 p. 407.

⁵²⁰ *Barentt v Chelsea and Kensington Hospital Management Committee* [1969] 1 QB 428.

⁵²¹ *Ibid.*

⁵²² *Ibid.*

⁵²³ M Lunney and K Oliphant *Tort Law Text and Masteries* p. 210.

patient claims he has been injured because he had not received adequate information, the patient has to establish that the proper disclosure of information would have meant that he would not have consented to the treatment, and, as a result, that he would not have suffered the injury.⁵²⁴ In other words, ‘but for the defendant’s negligence the patient would have suffered an injury’.⁵²⁵ Thus, it is not sufficient to just establish that doctors are negligent⁵²⁶ but also the negligence must cause damage to the claimant as a result of not having been given the relevant information.⁵²⁷ However, as with the standard of care, there are different approaches to determining whether the failure to disclose information has in fact been the cause of the patient’s injury. A distinction can be drawn between a subjective test of causation and an objective test.

The subjective test of causation relies on a particular patient’s evidence as to what s/he would have done if given the information, so to establish his case s/he would simply need to give evidence that s/he would not have consented to the treatment. It has been argued that the test of causation in information disclosure cases was considered by McNair J in *Bolam* as a subjective one.⁵²⁸ Here he held that ‘... you might well take the view that unless the plaintiff [the patient] has satisfied you that he would not have taken the treatment if he had been warned, there is really nothing in this point’.⁵²⁹ Further, it has been argued that in *Chatterton* Bristow J also adopted a subjective test of causation as he held that ‘[w]hen the claim is based on negligence the plaintiff [the patient] must prove not only the breach of duty to inform, but that had the duty not been broken she would not have chosen to have the operation’.⁵³⁰ However, Bristow J appeared to acknowledge a different test, a more objective one.⁵³¹ The objective test of causation relies on deciding what a reasonable patient would have chosen to do if given the information.⁵³² In *Chatterton*, Bristow J held that ‘I would not have been satisfied that if properly informed the plaintiff [the patient] would have chosen not to have it [the operation]. The whole picture on the evidence is of a lady desperate for pain relief...’⁵³³ In other words, a reasonable patient in the circumstances of the patient

⁵²⁴ E Jackson *Medical Law Text, Cases and Materials* p. 194.

⁵²⁵ J Herring *Medical Law and Ethics* p. 114.

⁵²⁶ *Ibid.*

⁵²⁷ *Thompson v Bradford* [2005] EWCA Civ 1439. See also *Wilsher Respondent v Essex Area Health Authority Appellants* [1988] A.C. 1074.

⁵²⁸ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 184.

⁵²⁹ *Bolam v Friern Hospital Management Committee* [1957] 1 W.L.R. 582 p. 590.

⁵³⁰ *Chatterton v Gerson* [1981] Q.B. 432 at 442.

⁵³¹ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 184.

⁵³² *Muir v Glasgow Corporation* 1943 S.C. (H.L.) 3 p. 10. Lord MacMillan.

⁵³³ *Chatterton v Gerson* [1981] Q.B. 432 p. 445.

would be expected to have consented to the treatment. This arguably shows that the outcome of *Chatterton* is to have a ‘hybrid test of causation’ that would require the patients to ‘show what they would actually have done had they been properly informed, but this subjective claim is the subjected to an objective test of credibility’.⁵³⁴ The credibility of the patient is tested against what it is considered a reasonable patient would have done in order to avoid the problem of the patient’s response being affected by the benefit of hindsight, whether deliberately or unconsciously. This kind of difficulty was discussed earlier in relation to the subjective and objective test for the standard of care.

Although it has been argued that ‘the subjective test is the most respecting of the patient’s self-determination, it may be difficult to apply it in practice without allowing the concept of reasonableness to creep in.’⁵³⁵ Nevertheless, ‘[t]he postcedent requirement for reasons, whether subjective, credible or wholly objective, undermines the antecedent right to decide irrespective of having a reason for the decision.’⁵³⁶

However, the mixture of a subjective/objective test of causation was adopted in *Smith v Barking, Havering and Brentwood HA*.⁵³⁷ The patient was required to provide evidence of what he would have decided if properly informed (subjective test). However, it was held that even if the witness was thought to be expressing their honest belief now about what they would have done, the court could conclude that a reasonable patient in the patient’s position would still have consented (objective test).⁵³⁸ Hence, if a reasonable patient would have agreed to a treatment that has been proposed to him even if he had been informed about the risk, the patient would carry the burden to bring evidence to support his allegation that he would have not consented to the treatment.⁵³⁹ However, the situation remains unclear and some English law cases seem to have continued to consider the subjective test of causation as a means for judges to assess ‘witness credibility’.⁵⁴⁰ For example, in *O’Keefe v Harvey-Kemble*,⁵⁴¹ the patient claimed that if she had been properly informed about the risks, she would not have consented to the surgery. The court held that,

⁵³⁴ A MacLean *Autonomy, Informed Consent and Medical Law a Relational Challenge* p. 184.

⁵³⁵ *Ibid.* p. 186.

⁵³⁶ *Ibid.* p. 187.

⁵³⁷ *Smith v Barking, Havering and Brentwood HA* [1994] 5 Med. L.R. 285.

⁵³⁸ A Grubb *et al Principles of Medical Law* para 6.54 p. 350 and M Jones *Medical Negligence* para 7.064 p. 699-701.

⁵³⁹ E Jackson ‘Informed Consent to Medical Treatment and the Importance of Tort’ p. 283.

⁵⁴⁰ E Jackson *Medical Law Text, Cases and Materials* p. 196

⁵⁴¹ *O’Keefe v Harvey-Kemble CA* [1998] 45 BMLR.

‘there were weighty arguments for the defendant...as to why the defendant’s version of events should have been preferred; alternatively, that... [the patient] would have been likely to proceed with the operation whatever warnings she received from the defendant. However, in the event, the recorder preferred the recollection of... [the patient] and accepted her evidence as to whether she would have proceeded is she had been fully and properly advised of the attendant risks. Those were essentially findings of fact based on the recorder’s assessment of the witnesses, of a kind with which this court will only interfere in rare cases.’⁵⁴²

Despite the success for the patient in this case, it has been argued that in addition to the problems with establishing breach of the duty of care, ‘...until the judgment in *Chester v Afshar*, causation also remained a very significant obstacle to patient success’.⁵⁴³ (Her emphasis). However, in *Chester* the court has relaxed the test of causation in an effort to give more respect for patient autonomy.⁵⁴⁴ As I have stated above, *Chester* is an important decision for both the development of the standard of information disclosure which has been discussed and for the issue of causation. In *Chester*, Chester was claiming that ‘if she had been told of the risks as she now knew them to be she would not have had the operation...’.⁵⁴⁵ Notably, Chester did not argue that she would not ever have consented to such an operation, but only that she would not have consented immediately to the operation until she had ‘...at least two further opinions as to whether an operation was necessary’.⁵⁴⁶ In *Chester* the majority of the Lordships (Lords Hope, Steyn and Walker) were in favour of Chester on causation as she lost the chance to have the operation on another day when it was suggested that, due to the low risk, it was unlikely she would have suffered paralysis.⁵⁴⁷ In terms of the test of causation, the majority of the Law Lords held that it is not necessary for the patient to prove she would never have consented to the operation for the rest for her life if she had been properly informed.⁵⁴⁸ Lord Hope stated that:

‘The function of law is to protect the patient right’s to choose. If it is to fulfil that function it must ensure that the duty to inform is respected by the doctor. It will fail to do this if an appropriate remedy cannot be given if the duty is breached and the very risk that patient should have been told about occurs and she suffers injury.’⁵⁴⁹

⁵⁴² *Ibid.* Per Neill LJ.

⁵⁴³ S McLean *Autonomy, Consent and the Law* p. 93

⁵⁴⁴ J Miola ‘Autonomy Rued OK?’ p. 112

⁵⁴⁵ *Chester v Afshar* [2004] UKHL 41 para 44

⁵⁴⁶ *Ibid.*

⁵⁴⁷ M Brazier and E Cave *Medicine, Patients and the Law* p. 132-133

⁵⁴⁸ *Chester v Afshar* [2004] UKHL 41 para 12

⁵⁴⁹ *Ibid.* para 56.

This approach can be understood to respect patients' self-determination as Lord Hope in the House of Lords cited with approval the decision of the Court of Appeal:

‘The object is to enable the patient to decide whether or not to run the risks of having that operation at that time. If the doctor’s failure to take that care results in her consenting to an operation to which she would not otherwise have given her consent, the purpose of that rule would be thwarted if he were not to be held responsible when the very risk about which he failed to warn her materialises and causes her an injury which she would not have suffered then and there.’⁵⁵⁰

The majority in the House of Lords in *Chester* can be said to have agreed to give ‘proper legal force to patients’ right to autonomy and dignity’.⁵⁵¹ Lord Steyn justified making what he referred to as ‘a narrow and modest departure from traditional causation principles.’⁵⁵²

The doctor has a duty to inform and failure to do so would result in negligence which should be compensated, even where there might have been considered to be difficulties in establishing causation.⁵⁵³ Therefore, *Chester* in relation to causation can be suggested to focus on the notion that the patient should be warned about risks as otherwise she would not have been given the opportunity to weigh the risks to make her choice.⁵⁵⁴ As Lord Hope argued: ‘For some [patients] the choice may be easy—simply to agree to or to decline the operation. But for many the choice will be a difficult one, requiring time to think, to take advice and to weigh up the alternatives’.⁵⁵⁵ Therefore, ‘[t]he duty is owed as much to the patient who, if warned, would find the decision difficult as to the patient who would find it simple and could give a clear answer to the doctor one way or the other immediately’.⁵⁵⁶

Although both Lords Bingham and Hoffman recognised the important of the patient’s right to be informed, they dissented from this approach to causation. Instead they opted for the conventional principle of causation provided by the ‘but for’ test, saying that the patient had failed it, because the stated time of performing the operation did not affect the risk of her injury.⁵⁵⁷ It has been argued that there would be a difficulty if a patient was asked to establish that ‘she would not have consented to have this particular treatment at this time if she had been properly informed, but cannot prove that she would never have undergone the

⁵⁵⁰ *Ibid.* para 65.

⁵⁵¹ M Brazier and E Cave *Medicine, Patients and the Law* p. 203.

⁵⁵² *Chester v Afshar* [2004] UKHL 41 para 24.

⁵⁵³ J Herring *Medical Law and Ethics* p. 169.

⁵⁵⁴ E Jackson *Medical Law Text, Cases and Materials* p. 199.

⁵⁵⁵ *Chester v Afshar* [2004] UKHL 41 para 86.

⁵⁵⁶ *Ibid.*

⁵⁵⁷ *Ibid.* para 8 and 30.

procedure in the future.⁵⁵⁸ This difficulty arises because it does not seem to fall clearly within the ‘but for’ test explained earlier.⁵⁵⁹ In a situation like this, if the risk is inherent in treatment, it seems hard to say how she would have avoided the same injury if she would still have undertaken the same treatment at a future time. The argument would be that any time that the operation was performed would subject her to the same level of risk. Deferring the operation would only delay the injury occurring. This is because in actions based on negligent information disclosure it is not contended that the doctor could or should have performed the treatment differently, so that the only way the patient could avoid injury would be to not have the treatment.⁵⁶⁰

In this regard, I would agree with Pattinson that the test of establishing causation in failing to disclose risks based on the majority in *Chester* can be formulated as the following: ‘A doctor who fails to disclose sufficient information thereby triggers potential liability even if that failure does not actually cause the patient any physical harm.’⁵⁶¹ This in fact only requires the patient to show that the disclosure of risk would have deprived him from making a choice, thus the patient needs to prove that he would not have consented to the medical treatment or operation at that time.⁵⁶² It has been argued that *Chester* has shown that the law of negligence is capable of protecting patient autonomy, because negligence is ‘actionable upon proof of damage, rather than actionable per se.’⁵⁶³ The ‘damage’ here is being regarded as the violation of patient autonomy. However, this is a significant departure from the traditional ‘but for’ test and is controversial since, as the minority argued, it could be regarded as being illogical.

According to *Montgomery*, the traditional ‘but for’ test was applied so that the patient must show that she would have taken a different decision, had she been properly informed.⁵⁶⁴ This was because it was not alleged that she would have sought further opinions and delayed the treatment, but might have opted for the same treatment at some later date. It was quite clear that her argument was based on which treatment she would have opted for at the time. In the Outer House of the Court of Session, the judge, by applying the subjective test of causation,

⁵⁵⁸ E Jackson *Medical Law Text, Cases and Materials* p. 197.

⁵⁵⁹ *Ibid.*

⁵⁶⁰ For example, L Khoury ‘*Chester v Afshar: Stepping Further Away from Causation?*’ (2005) *Singapore Journal of Legal Studies* 246–260.

⁵⁶¹ S Pattinson *Medical Law and Ethics* p. 133.

⁵⁶² J Mason *The Troubled Pregnancy: Legal Wrongs and Rights in Reproduction* (1st ed CUP 2007) p. 76-77.

⁵⁶³ S Pattinson *Medical Law and Ethics* p. 134.

⁵⁶⁴ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 104 and N Khaliq ‘*Informed Consent: The Dawning of a New Era*’ (2015) 53(6) *British Journal of Oral and Maxillofacial Surgery* 479-484.

came to the conclusion that, even if Montgomery had been given full advice about the risks of the shoulder dystocia, she would not have selected the alternative of a Caesarean section. That conclusion was approved by the Inner House of the Court of Session.⁵⁶⁵ Nevertheless, the Scottish courts' conclusion regarding causation contained two errors, as the Supreme Court has observed. First, the courts focussed on the very small risk of a severe result of the shoulder dystocia ('1/500 approximately for a brachial plexus injury and of that 1/500 approximately 1–2% of those would suffer cerebral palsy. '),⁵⁶⁶ instead of the significant risks of shoulder dystocia itself (9% to 10%).⁵⁶⁷ Second, the courts excluded a vital piece of evidence which was submitted by Dr McLellan herself, when she explained that she did not warn about shoulder dystocia, because based on her view that 'most women will actually say, 'I'd rather have a caesarean section.'⁵⁶⁸ She then explained that if she mentioned such risks to diabetic patients, most of the women would opt for a Caesarean section, which in her view was '...not in the maternal interests..' for them.⁵⁶⁹ The Supreme Court concluded that had Dr McLellan

'...advised Mrs Montgomery of the risk of shoulder dystocia and discussed with her dispassionately the potential consequences, and the alternative of an elective caesarean section, Mrs Montgomery would probably have elected to be delivered of her baby by caesarean section. It is not in dispute that the baby would then have been born unharmed.'⁵⁷⁰

The evidence thus has appeared to show that even the defender believed that giving such information was likely to change the patient's mind about treatment and accordingly the Supreme Court held that the causation point was established in the patient's favour.⁵⁷¹ It should also be noted that Dr McLellan's view is reminiscent of the now discredited approach that it is appropriate to withhold information if it is believed that this is in the patient's best medical interests. This paternalistic approach is no longer accepted, save for rare cases where therapeutic exception can be invoked. It can be argued that the element of causation in *Montgomery* was straightforward. Therefore, '[a]s such causation was satisfied in the ordinary fashion, discussion of *Chester v Afshar* was unnecessary.'⁵⁷² (Original emphasis)

⁵⁶⁵ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 96.

⁵⁶⁶ *Montgomery v Lanarkshire Health Board* [2010] CSOH 104 para 229.

⁵⁶⁷ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 99-100.

⁵⁶⁸ *Ibid.* para 13.

⁵⁶⁹ *Ibid.*

⁵⁷⁰ *Ibid.* para 104.

⁵⁷¹ *Ibid.* para 103.

⁵⁷² C McGrath 'Trust me, I'm a Patient': Disclosure Standards and the Patient's Right to Decide' p. 214.

In conclusion, since the decision in *Chester* has been handed down English law has become more willing to protect patients' autonomy. It seems that by relaxing the conditions of causation for the patient to establish his claim English law is giving more support to patients to prove their claims. The issue of causation is very interesting and shows another aspect of how the law considers the protection of the patient's autonomy.⁵⁷³ Nonetheless, as the major focus in this thesis is on the issue of the standard of care in relation to information disclosure, I have limited the discussion of the issue of causation and I will not further consider it in this Chapter.

5. Conclusion

This Chapter has discussed English law with regard to consent and information disclosure, and has focused on the issue of how English law has interpreted the principle of respect for autonomy in terms of adult competent patients' consent and information disclosure. I would agree that consent to medical treatment 'is much more than a medico-legal concept, as it encompasses a number of moral precepts relating to freedom of choice and the right to decide whether or not to accept advice and treatment'.⁵⁷⁴ As a result, it has been said that 'the doctor's legal duty to obtain consent for treatment is based on the fundamental principle of respect for the individual's right to self-determination and autonomy'.⁵⁷⁵ Hence, Lord Donaldson demonstrated a strong view regarding respect for autonomy when His Lordship affirmed that: 'An adult patient who...suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatment being offered...'.⁵⁷⁶ His Lordship then has added: 'This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even nonexistent'.⁵⁷⁷ Lord Donaldson stated that '[t]he patient's interest consists of his right to self-determination - his right to live his own life how he wishes, even if it will damage his health ...'.⁵⁷⁸

⁵⁷³ A MacLean 'From Sidaway to Pearce and Beyond: Is the Legal Regulation of Consent any Better Following a Quarter of a Century of Judicial Scrutiny?' p. 126.

⁵⁷⁴ H Cheung 'Consent to Medical Procedures-Principles and Practice' (1995) 5 *Hong Kong Journal of Psychiatry* 5-17 p. 8.

⁵⁷⁵ A Plomer *The Law and Ethics of Medical Research: International Bioethics and Human Rights* (Cavendish Publishing limited 2005) p. 49.

⁵⁷⁶ *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95 p. 102.

⁵⁷⁷ *Ibid.*

⁵⁷⁸ *Ibid.* p. 112.

It is clear that when the law considers consent under battery it is to protect patients' bodily integrity from unwanted touching⁵⁷⁹ and a legally valid consent requires the patient to be competent and free from undue influence or coercion.⁵⁸⁰ It also requires a certain amount of information disclosure. However, once consent based on a broad understanding of the nature of the treatment has been obtained, any failure in provision of adequate information is dealt with by the civil tort of negligence. Adequate information disclosure is undoubtedly required by the law but the precise scope of information to be disclosed has undergone changes culminating in the case of *Montgomery*.⁵⁸¹

The increased emphasis on respect for patient autonomy discussed in Chapter one has also been seen in the development of English law to acknowledge this principle, as can be seen most strongly in *Montgomery*, with its formulation of the prudent patient standard of care in actions for negligence based on inadequate information disclosure.⁵⁸² In Lady Hale's words in this case:

'It is now well recognised that the interest which the law of negligence protects is a person's interest in their own physical and psychiatric integrity, an important feature of which is their autonomy, their freedom to decide what shall and shall not be done with their body...'⁵⁸³

Therefore, for Lady Hale the patient is entitled to make her decision freely and that decision must be respected as long as the patient is 'a competent adult' and the patient is 'entitled to the information which will enable her to take a proper part in that decision.'⁵⁸⁴

The acknowledgment of the need for the law to protect patient autonomy in the earlier cases of *Chester* and *Pearce* has been described by Hoppe and Miola as 'stark.'⁵⁸⁵ That has led them to express their strong belief that, in less than twenty years, English law has moved from Lord Diplock's view to purely applying the *Bolam* test where there is no mention of respect for patient autonomy, through Lord Bridge's modified view, then more recently to the protection of patient autonomy in much the way that Lord Scarman in *Sidaway* proposed.⁵⁸⁶

⁵⁷⁹ For example, *Re W (A Minor) (Medical Treatment)* [1992] 4 All ER 627 and *Freeman v Home Office* [1984] QB 524.

⁵⁸⁰ For example, *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95.

⁵⁸¹ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 87.

⁵⁸² C Foster 'Montgomery Is the Belated Obituary, Not the Death Knell, of Medical Paternalism, says Charles Foster' at [http://www.newLawjournal.co.uk/nlj/content/last-word-consent](http://www.newlawjournal.co.uk/nlj/content/last-word-consent) (accessed 29/05/2015).

⁵⁸³ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 108.

⁵⁸⁴ *Ibid.* para 115.

⁵⁸⁵ N Hoppe and J Miola *Medical Law and Medical Ethics* p. 88.

⁵⁸⁶ *Ibid.* p. 88-89.

I would agree with Miola's observation that English judicial view on the standard of care has been gradually changed as follows:

‘The judicial attitude gradually changed, and the focus of the law shifted from doctors to patients. The legal test for what a doctor must tell a patient... moved... to what the reasonable doctor would inform a patient subject to judicial control, [*Smith v Tunbridge Wells HA*] and then to what the reasonable patient would want to be told [*Pearce v United Bristol Healthcare NHS Trust*]. This provided limits to the use of medical conscience, as the law came to prioritise what the patient wanted rather than what the doctor thought best for the patient. But the courts have gone further, and the law now openly and explicitly looks only at patient autonomy. Indeed, the Supreme Court has recently delivered a judgment that cements this view in *Montgomery v Lanarkshire Health Board*.’⁵⁸⁷ (Original emphasis).

However, English law still acknowledges the therapeutic privilege concept,⁵⁸⁸ so as to allow doctors in some exceptional circumstances to withhold information from their patients, based on their medical judgement.⁵⁸⁹ Nevertheless, the scope for this has become very limited.⁵⁹⁰

In Chapter one, this thesis discussed the Western ethical views on the principle of respect for autonomy and trust in a medical context. It was proposed that patients should be provided with sufficient and understandable information to be self-determining. For the reasons I have stated throughout this Chapter modern English law (the prudent patient standard) seems to be able to satisfy the thesis's proposed ethical standard. There do remain issues to be resolved such as the issue of what is meant by informing the patient about a reasonable alternative treatment and how doctors should fulfil their duties to seek to ensure that the patient can understand the information. Clarification of these remaining questions will doubtless emerge from future case law.

The next Chapter will examine the Saudi Arabian current professional standard of care in order to make recommendations for reform. Therefore, in the following Chapter, the thesis will move its focus to consider the same issues as discussed in this Chapter but based on the Islamic *Sharia* and Saudi Arabian laws. Then, in the Concluding Chapter, the thesis will present the lesson that can be learnt from English law experience based on the conclusions of the previous Chapters.

⁵⁸⁷ J Miola 'Making Decisions about Decision-Making: Conscience, Regulation and the Law' p. 277.

⁵⁸⁸ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 and *Chester v Afshar* [2004] UKHL 41.

⁵⁸⁹ *Ibid.*

⁵⁹⁰ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 95 and *Chester v Afshar* [2004] UKHL 41.

Chapter four: Islamic *Sharia* and Saudi Arabian law on consent and information disclosure

1. Preface

The standard of care that has been applied by Saudi Arabia's SMPs¹ and hospitals is the professional standard of care. The Saudi Arabian professional standard is based on the perspective of Muslim scholars, which is that doctors' civil liabilities should be determined by the relevant profession, not by the courts reaching an independent judgment on appropriate conduct. In this sense the standard, as Yacoub has noted, can be considered to take the same approach as that adopted in the English case of *Bolam v Friern Hospital Management Committee*², by using a professional standard.³ Furthermore, I will argue that the Saudi Arabian professional standard in its current form and application is in fact in accordance with Lord Diplock's version of the standard of care in *Sidaway v Bethlem Royal Hospital Governors*⁴ and it has been applied to all aspects of doctors' duties of care, including information disclosure.

Chapter two of the thesis discussed the notion of the principle of respect for autonomy based on Islamic *Sharia* and Saudi Arabian medical ethics. The Chapter concluded that both Islamic *Sharia* and Saudi Arabian medical ethics have recognised the principle of respect for autonomy, albeit with some reservations concerning permissible decisions. Respect for autonomy should not lead to severe harm or death or an action that is against Islamic *Sharia* principles, even that action is harmless.⁵ However, having discussed the standard of information disclosure in Chapter two, it seems that there is no clear reference by either Islamic *Sharia* or Saudi Arabian medical ethics to such an issue nor other matters arising from information disclosure. Nevertheless, I have argued that the proposed ethical standard I have adopted can be applied in Saudi Arabia, with the addition that consent to or refusal of treatment must be in accordance with Islamic *Sharia* principles. I have concluded that the available materials in Saudi Arabian medical ethics, set out in CEHP2013, are not sufficiently developed in the light of the proposed ethical standard.

¹ See their role below in this Chapter.

² *Bolam v Friern Hospital Management Committee* [1957] 1 W.L.R. 582.

³ A Yacoub *The Fiqh of Medicine Responses in Islamic Jurisprudence to Developments in Medical Science* p. 111-112

⁴ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871

⁵ See Chapter two for further discussion.

The recognition by Islamic *Sharia* of respect for patients' autonomy would support the thesis's argument that Saudi Arabian medical law should provide protection for patient autonomy. It will be argued in this Chapter that LPHP2005 does not provide adequate protection of patients' autonomy, because of its use of the professional standard for information disclosure and its failure to address certain key issues. As noted in Chapter two, reforming the current deficiency and uncertainty in the standard of care for information disclosure in Saudi Arabia would need to be undertaken by the legislative bodies in the country, rather than relying on legal development through case law. It is also important to note that unless Islamic *Sharia* primary sources have given a view on an issue which is considered to be a legal ruling, whatever Islamic *Sharia* medical ethics says about an issue cannot be legally binding until that view is adopted by the State.⁶ Although there have been some statements made by the GPSRI which are legally enforceable, there remain gaps and deficiencies. This will be explored further in this Chapter. Since there are sufficient similarities in Western medical ethics and Islamic *Sharia*, and *Montgomery v Lanarkshire Health Board*⁷ has developed English law toward what I contend meets an acceptable ethical standard. I would argue that it would be appropriate for Saudi Arabia to consider the experience that has been developed in the UK regarding the legal standard of care in information disclosure and, where appropriate and in accordance with Islamic *Sharia* principles, learn some lessons from it. However, as has been stated in Chapter two that there are some differences between the approaches to respect for autonomy that would need to be taken into account by any legislation in Saudi Arabia. The novelty of this thesis is to recommend that LPHP2005 introduces the prudent patient standard of care because respecting patients' autonomy in a way that is consistent with Islamic *Sharia* is not sufficiently provided for in specific laws.

I would argue that there is some evidence that supports the introduction and adoption of the prudent patient standard in Saudi Arabia. For example, in Chapter two I have argued that Islamic *Sharia* medical ethics and general principles can recognise the prudent patient standard. Additionally, the attitudes of patients and medical professionals are changing in Saudi Arabia and there seems to be more awareness of the need for more protection of respect for patients' autonomy, as AlBar and Pasha have argued.⁸ In this Chapter, I will

⁶ For further discussion, M Asad *The Principles of State and Government in Islam* (Literary Licensing 2011).

⁷ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11

⁸ M AlBar and H Pasha *Contemporary Bioethics Islamic Perspective* p. 111

discuss some recent surveys and studies that show the current attitudes of patients and doctors in Saudi Arabia regarding autonomy and informed consent.

In regard to the discussion in this Chapter, as for any country in the world, for Saudi Arabia to enforce the sovereignty of its laws, the law should be applicable to all residents in the country.⁹ Thus, medical staff who work in Saudi Arabian hospitals, irrespective of their backgrounds, should follow the medical regulations of the country.¹⁰ The existing LPHP2005 has no reference to a specific patient faith or background or schools of thought: its principles have been set for all patients. Taking into consideration that the country is an Islamic country, it is clear that the principles are set based on Islamic *Sharia* and for Muslims but LPHP2005 is applicable to all patients who are receiving healthcare in the country and all doctors providing it. The BLG1992 has declared that the government of Saudi Arabia shall protect human rights in accordance with Islamic *Sharia*.¹¹ Furthermore, LPHP2005 has stated that: ‘Healthcare professionals shall serve the best interest of individuals and society within the framework of respecting human right to life, safety and dignity and shall observe customs and traditions prevailing in the Kingdom, and eschew exploitation.’¹² Therefore, it might be possible for doctors to respect patients’ views from other backgrounds as long as that does not require them to breach Islamic *Sharia* or Saudi Arabian law.¹³ For example, a doctor cannot assist the patient to die even at the patient’s own request: ‘[u]nder no circumstances may the life of a terminally ill patient be terminated even if so requested by the patient or his family.’¹⁴ In this example, the stance of Saudi Arabian law is similar to English law, as it is still illegal to recognise the patient’s right to die by the active assistance of another,¹⁵ regardless of the patient’s nationality, religion or background. Thus, in Saudi Arabia non-Muslim patients’ views can and should be respected as long as that is not in breach of Islamic *Sharia*, and this should also be taken into account in any proposed legal reform. The objectives of this Chapter are: first, to examine the development of the law of consent under Islamic *Sharia* and Saudi Arabian medical law. Second, to present the current way in which the law is applied and to demonstrate where there are gaps in medical law in

⁹ There are very limited reservations such as to allow non-Muslims in private to drink alcohol or celebrate their festivals or practice their religions. For example, ‘Foreign travel advice Saudi Arabia’ by The UK government at <https://www.gov.uk/foreign-travel-advice/saudi-arabia/local-laws-and-customs> (accessed 01/07/2015).

¹⁰ LPHP2005 articles 1 and 5.

¹¹ BLG1992 article 26.

¹² LPHP2005 article 5.

¹³ Ibid. article 5 section 1 in the executive regulation has stated that: ‘Healthcare professionals must respect patients’ choices in accordance with Islamic *Sharia* and law’ (Arabic).

¹⁴ Ibid. article 19.

¹⁵ See Chapter one for further discussion.

relation to how much information should be given. Third, it will examine whether the Saudi Arabian legal standard of information disclosure respects the competent adult patient's autonomy in way that is in accordance with Islamic *Sharia*. Fourthly, it will examine the legal consequences of doctors' liability for failure to obtain patients' consent or disclose information or risks to them. For each matter that has a deficiency, it will be compared to the English law experience so as to explore whether some lessons can be learnt. Finally, in the Concluding Chapter the thesis will present its recommendation to Saudi Arabian medical law to adopt the prudent patient standard of care.

The discussion and analysis in this Chapter will rely on LPHP2005, medical declarations from the GPSRI¹⁶ and CEHP2013.¹⁷

2. Patients' consent (*AlEden*) and Saudi Arabian medical law

Consent normally means what the patient permits to be done to his/her body and which kind of medical procedure he/she agrees should be conducted.¹⁸ The thesis will now discuss how the law of consent has been developed in Saudi Arabia, until it reached its final formulation in LPHP2005 and CEHP2013. It will do so first through a brief consideration of the Islamic *Sharia* legal perspective. As discussed in Chapter two, Islamic *Sharia* legal principles are based on the same sources as religious and ethical principles, but the consequences of breaching them differ.

2.1. Islamic *Sharia* legal perspective

Muslim scholars have considered the law of consent by grounding their analysis and understanding on the primary sources of Islamic *Sharia*. The holy *Quran* in translation states: 'O you who believe, do not enter other houses except yours without first asking permission and saluting the inmates. This is better for you: you may haply take heed.'¹⁹ Muslim scholars understood from this holy verse that the holy *Quran* grants people's homes privacy and protection to not be entered unless permission has been granted.²⁰ Based on this, Muslim scholars have stated their views regarding dealing with one's property in Islamic *Sharia* legal formulae: 'The dealing by one person with the property of another, without his

¹⁶ Its role is described in Chapter two.

¹⁷ See Chapter two for its legal binding.

¹⁸ M AlShanqeeti, *Ahkam Algerhah Altibeh wAlather Almotrtbh Aliha. (Rulings of Medical Surgeries and Their Consequences)*. p. 160.

¹⁹ The holy *Quran* in translation (CH24:27).

²⁰ Ibn Kathir *Tafsir ibn Kathir (The Interpretation of the Holy Quran)* (1st ed Dar ibn Hazm 2000) p. 1324.

leave, is not lawful'.²¹ If this protection is given to people's homes then it is considered that an individual's rights to privacy and bodily integrity are even more valuable and to be protected, since the holy *Quran* in translation describes the human body as follows: 'We [Allah] have indeed created man in the best shape.'²² Islamic *Sharia* has recognised the protection of the sanctity of human life and respect for the human body, as the Messenger PBUH declared in the holy place of Makkah²³ during his pilgrimage: 'verily your blood, your property are as sacred and inviolable as the sacredness of this day of yours, in this month of yours, in this town of yours'.²⁴

It is therefore clear that the human body and life are sacred and to be protected from any violence or other action that threatens them.²⁵ It follows that each individual must be protected from any unwanted touching – reckless, well meaning or malicious. It is a breach of bodily integrity if one deals with a person's body without a person giving permission or consent in a way that is in accordance with Islamic *Sharia* teachings.²⁶

Muslims are encouraged to preserve, promote and enjoy their lives in a good way; the holy *Quran* in translation states:

'But seek, with that (wealth) which Allah has bestowed on you, the home of the Hereafter, and forget not your portion of legal enjoyment in this world, and do good as Allah has been good to you, and seek not mischief in the land. Verily, Allah likes not the *Mufsidun* (those who commit great crimes and sins, oppressors, tyrants, mischief-makers, corrupters).'²⁷

Therefore, based on what has been said, it can be argued that first, an individual is in control of his/her own body, and second, that body may not be violated by any means unless the person has consented to something that benefits him/her or prevents severe harm or death and is not against Islamic *Sharia* principles. There have been some references to the law of patients' consent to or refusal of medical treatment in Islamic *Sharia* traditions, perhaps not to a degree that would satisfy the current formulation of consent laws, but advanced concepts

²¹The Mejlle Being an English Translation of Majallah El-Ahakam-I-Adliya and a Complete Code on Islamic Civil Law. Article 96.

²² The holy *Quran* in translation (CH95:4).

²³ This declaration was made by Messenger Mohammad PBUH in the performance of *Hajj* (pilgrimage) in Makkah in 631.

²⁴ M AlHajja *Sahih Muslim* and M AlBukhari *Al-Bukhari* at <http://sunnah.com/riyadussaliheen/18/14> (accessed 10/12/2014).

²⁵ A Badwi *The Concise Presentation of the Fiqh of the Sunnah and the Noble Book* translated by J Zarabozo (2nd ed IIPH 2007) p. 505-506

²⁶ M Abdulfattah *Simplified Islamic Jurisprudence Based on the Quran and the Sunnah* (Dar AlManarah 2004) Vol 2 p. 1009

²⁷ The holy *Quran* in translation (CH28:77).

for their time. There was a specific reference that bears directly upon consent to treatment in one of Islamic *Sharia*'s primary sources, *Sunnah*, when the Messenger PBUH was ill²⁸ and in need of treatment, as those who were surrounding him PBUH thought. His wife Aisha²⁹ told the story:

‘We poured medicine³⁰ into the mouth of Allah’s Messenger during his illness, and he pointed out to us intending to say, ‘Do not pour medicine into my mouth.’ We thought that his refusal was out of the aversion a patient usually has for medicine. When he improved and felt a bit better, he said (to us.) ‘Did not I forbid you to pour medicine into my mouth?’ We said, ‘we thought (you did so) because of the aversion, one usually has for medicine.’ Allah’s Messenger said, ‘There is none of you but will be forced to drink [the same] medicine, and I will watch you, except Al-‘Abbas [his uncle], for he did not witness this act of yours.’³¹

From this prophetic statement, Muslim scholars have elicited some legal principles in relation to patients’ consent to or refusal of medical treatment.

First, this prophetic statement by the Messenger PBUH has been believed to be the foundation of the Islamic *Sharia* law of consent to or refusal of medical treatment.³² Therefore, a competent adult patient is the only person legally entitled to consent to or refuse medical treatment. This principle has been recognised by the GPSRI, LPHP2005 and CEHP2013, as will be discussed in this Chapter.

Second, Muslim scholars from the prophetic statement above have agreed that it is not normally permitted to consent to or refuse treatment on behalf of competent adult patients.³³ There are some limited exceptions, for example, in an emergency where it is difficult and impractical to obtain or wait for consent and the treatment is required to save patients’ lives or prevent them from severe harm or damage to their health, based on the Islamic *Sharia*

²⁸ The story took place a few weeks before the Messenger PBUH died in 631.

²⁹ For her biography, S Aleem *Prophet Muhammad (S) and His Family: A Sociological Perspective* (1st ed Author House 2011) p. 96-105

³⁰ The medicine was ‘Indian wood, *Warss* (the Ceylon Cornel tree) and drops of olive oil’ M Ibn Qayyim alJawziyyah, *Healing with the Medicine of the Messenger* p. 81- 83

³¹ M AlBkhari *Sahih AlBukhari* at <http://sunnah.com/bukhari/64/474> (accessed 10/12/2014).

³² M Ibn Qayyim alJawziyyah, *Healing with the Medicine of the Messenger* p. 83.

³³ See for example GPSRI declaration which stated that: ‘Patients, who are adult and of sound mind, are more entitled than anybody regarding taking a decision about whether or not they should undergo a surgical operation, under such circumstances no one, can claim the right of *Wilayah* (guardianship) over them.’ No date or number. GPSRI at <http://www.alifta.net/Fatawa/FatawaChapters.aspx?View=Page&PageID=170&PageNo=1&BookID=17> (accessed 05/12/2014).

principle of necessity.³⁴ This principle has been recognised by the GPSRI, LPHP2005 and CEHP2013, as will be discussed in this Chapter.

Third, Muslim scholars have understood from the prophetic action when the Messenger PBUH gestured to those who surrounded him to not give him PBUH the treatment, rather than telling them not to, that consent to or refusal of medical treatment can be expressed either implicitly or explicitly.³⁵ LPHP2005 and CEHP2013 have not provided instructions on how the patient's consent should be obtained, except for specific cases mentioned in CEHP2013. I will revisit this issue later on in this Chapter.

Fourth, there is a prohibition on treatment decisions that would result in severe harm or death or be against Islamic *Sharia*. The holy *Quran* in translation states that: 'And do not kill yourselves (nor kill one another). Surely, Allah is Most Merciful to you.'³⁶ This means that if refusal or consent to treatment would lead to death (such as a patient consenting to take a fatal poison), the patient's decision would not be valid and he/she must be treated, because suicide and intentional homicide are legally prohibited according to Islamic *Sharia*, as the thesis has discussed in Chapter two.

The permissibility of actions under Islamic *Sharia* has also been discussed in Chapter two. The same five rulings are also relevant to a consideration of legal principles. Thus, it follows that the competent adult patient's obligation to seek treatment is divided by the use of the five rulings as follows:³⁷

(A) When the patient's obligation is *Makroh* (blameworthy) or *Mandob* (praiseworthy) or *Mobah* (indifferent) to consent to or refuse treatment, based on available knowledge, his/her consent or refusal should be respected,³⁸ such as normal flu or toothache or headaches and so forth. Thus, treating a competent adult patient without his/her consent in these cases is not only unethical, it is illegal, because the Messenger PBUH ordered the penalty of those who treated him PBUH without consent.³⁹ The holy *Quran* states in translation 'and if you punish [those who violated your rights], then punish them with the like of that with which

³⁴ H Alzohaele *Nadareit AlDroerah Alshriaeh (The Principle of Islamic Sharia Necessity)* (7thed Dar Alfiker 2007) p. 212-214 (Arabic).

³⁵ M AlShanqeeti, *Ahkam Algerhah Altibeh wAlather Almotrtbh Aliha. (Rulings of Medical Surgeries and Their Consequences)*. p. 168.

³⁶ The holy *Quran* in translation (CH29:4).

³⁷ A ibn Taymiyyah *Majmoo' al-Fatawa (Compilation of Fatawa)* (Maktabt Almaraf 1981) Vol 18 p. 12. (Arabic).

³⁸ M AlBar and H Pasha *Contemporary Bioethics Islamic Perspective* p. 89-91.

³⁹ M Ibn Qayyim alJawziyyah, *Healing with the Medicine of the Messenger* p. 83.

you were afflicted...⁴⁰ Accordingly, when the Messenger PBUH ordered that each should be punished by the same action they had committed, this showed that failure to treat without consent can be in general considered as a criminal offence, so that it is appropriate to punish those who deliberately treat a patient without valid consent under criminal law.⁴¹ Additionally, a civil remedy (compensation) must be paid to the patient for the damage that has been occurred. I will further discuss this issue under Saudi Arabian law later in this Chapter.

(B) When patients' obligation to seek treatment is *Wajib* (obligatory) and hence consent is obligatory (such as refusing a lifesaving blood transfusion),⁴² the patient's refusal of consent should be disregarded and the treatment should be administered.⁴³ The holy *Quran* has prohibited suicide,⁴⁴ and refusing treatment for a life-threatening curable illness can be considered to be an action of suicide, thus a penalty should be ordered.⁴⁵ The patient's failure to consent may lead a judge to order a discretionary penalty if the patient is still alive. For the same reason, since suicide and killing others is prohibited, if doctors respect the refusal of consent or fail to administer treatment they may also face a discretionary penalty based on their intentions and the circumstances.

(C) When patients' obligation to seek treatment is *Moharm* (forbidden) as the treatment cannot be consented to, consent must be disregarded, for example, the patient's consent to an illegal abortion.⁴⁶ In this case, both the patient and her doctor have committed a crime and they must face a criminal trial for breaching the law.⁴⁷

I will discuss further the legal consequences based on LPHP2005 in this Chapter, specifically in regard to information disclosure.

⁴⁰The holy *Quran* in translation (CH16:126).

⁴¹M Ibn Qayyim alJawziyyah, *Healing with the Medicine of the Messenger* p. 83.

⁴² M AlShanqeeti, *Ahkam Algerhah Altibeh wAlather Almotrtbh Aliha. (Rulings of Medical Surgeries and Their Consequences)*. p. 170-171.

⁴³ See Chapter two for further discussion.

⁴⁴ The holy *Quran* in translation (CH29:4).

⁴⁵ The Saudi Arabian has no written Criminal Code so it is left for the judge to order a discretionary penalty based on the action itself.

⁴⁶LPHP2005 stated in article 22 that '[a] physician may not perform abortion on a pregnant woman unless necessary for saving her life. However, abortion may be performed if pregnancy has not completed four months and it is conclusively established that the continuation of such pregnancy will have serious consequences on the mother's health, based on a decision by a medical committee formed in accordance with terms and conditions'.

⁴⁷ The judge may order discretionary penalty for the mother. On the other hand, the doctor will be fined (no more than SR100,000 or imprisoned (no more than 6 months) or both. LPHP2005 article 28.

Thus, from what has been discussed, it can be argued that Islamic *Sharia* jurisprudence has recognised the need to respect patients' autonomous decisions as a legal principle in relation to healthcare. Thus, consent to medical treatment in a basic form was considered to be a legal requirement many centuries ago by Islamic *Sharia*.⁴⁸ Having explained the basis of the legal principle, I will now turn to how that principle came to be enacted in modern times in regulation directed at medical professionals.

2.2. The development of consent law in Saudi Arabian medical laws

Saudi Arabian medical law has developed rapidly, especially in the last three decades, with increased attention being paid to health sectors.⁴⁹ Any Saudi Arabian regulations should be based on Islamic *Sharia*, should be interpreted in accordance with it and must not conflict with it.⁵⁰ I have explained elsewhere⁵¹ that, from the beginning of the 1910s to the middle of 1920s, Arabic traditional medicine prevailed and there was no statutory regulation of hospitals or clinics or medical professions until the License to Practice Medicine and Pharmacy 1928 addressed this.⁵² However, this Act did not address the issue of consent law and as a result of poor and unclear medical regulations, guidelines, and instructions, medical staff found themselves in a situation where they had to try to follow and apply Islamic *Sharia* law and Saudi Arabian traditions and customs and be sensitive to public attitudes in relation to the practice of medicine.⁵³

It has been explained that Islamic *Sharia* does contain reference to legal principles concerning consent to treatment. However, those principles need to be formed in a very clear code of law to be applied consistently in practice. As the thesis has also explained, the Saudi Arabian legal system has not considered precedent as a form of legal development.⁵⁴ However, until the beginning of the 1970s the *Mufti* was both the Head of Saudi scholars and also of Saudi judges.⁵⁵ The views of the *Mufti* before that time can be considered as amounting to statements of legal principle because of his dual power.⁵⁶ It can therefore be

⁴⁸ For example, S Selek, 'A Written Consent Five Centuries Ago' (2010) 36 *Journal of Medical Ethics* 639 and K Aljlouni 'History of Informed Medical Consent' (1995) 346 *Lancet* 980.

⁴⁹ M Alhadjaj 'Medical Practice in Saudi Arabia the Medico-Legal Aspect' (1996) 17(1) *Saudi Medical Journal* 1-4 p. 1.

⁵⁰ A Ansary 'A Brief Overview of the Saudi Arabian Legal System' at http://www.nyulawglobal.org/Globalex/Saudi_Arabia.htm#_edn118 (accessed 20/12/2014).

⁵¹ K Alghamdi 'Tatowir Tanzim Mahnat Altab wa Alsidalh be AlMammlakh Alarabeih AlSuudih' 'The Development of Saudi Arabian Medical and Pharmaceutical Professions' Regulations' (2011) 2 *Alqadaeya* 68-96. (Arabic).

⁵² *Ibid.* p. 70-72.

⁵³ O Alrabeeh and F Alfaleh *Alnadam Alshee AlSaudi (the Saudi Health System)* (1st ed Dar Alolom 2010) p. 37-39. (Arabic).

⁵⁴ See Chapter two for further discussion.

⁵⁵ M Hatina *Guardians of Faith in Modern Times: 'Ulama' in the Middle East* p. 211-230 and see also M Watson *Prophets and Princes: Saudi Arabia from Muhammad to the Present*. p. 331-395.

⁵⁶ S Shamma 'Law and Lawyers in Saudi Arabia' p. 1086

argued that there was a significant ruling on the law of consent by the Saudi Arabian legal system in the early 1960s, since an appeal was reviewed by the *Mufti*. The case involved a patient who died as a result of a cauterisation procedure performed by a doctor who was an expert in Arabic traditional medicine. The judge in the first degree court held that the doctor should not be charged for the death of the patient, because (1) the doctor is expert in the craft of practicing Arabic traditional medicine;(2) the doctor was not negligent, because he made an effort to treat the patient (confirmed by medical expert evidence); (3) the doctor treated the patient ‘...after taking his [the patient’s] permission.’⁵⁷ The *Mufti* (the Head of judges) upheld the judge’s decision and dismissed the appeal.⁵⁸

The case presents a variety of legal aspects which were considered, such as doctors’ liabilities in terms of the standard of treatment but the most important issue for this thesis is the mention of consent. The Practicing Medicine 1935 (the Act in force at that time)⁵⁹ did not provide any reference to obtaining patients’ consent, it only focused on the qualifications of the medical profession, doctors’ licences and so forth.⁶⁰ However, the judge in the first degree court and the Head of Judges (the *Mufti*) considered it relevant to refer to consent as a part of the proper practice of medicine at that time. Hence, it can be assumed that the judges considered that obtaining the patient’s consent was an important matter, but they did not address it in any detail, such as what needed to be disclosed in order for the consent to be considered valid.

In addition to the general uncertainty about what was required regarding obtaining patients’ consent to medical treatment where the patient was a competent adult male,⁶¹ there was another issue regarding a competent adult female’s consent to medical treatment.⁶² This generated particular problems in the area of the validity of her consent to medical treatment, as there was uncertainty about whether there was a need to seek a competent male guardian’s

⁵⁷ Case number 444 dated 28/3/1382 A.H. [29/08/1962], at <http://www.alifta.net/Fatawa/FatawaChapters.aspx?languagename=en&View=Page&PageID=161&PageNo=1&BookID=17> (accessed 20/12/2014).

⁵⁸ *Ibid.*

⁵⁹ K Alghamdi ‘Tatowr Tanzim Mehnat Altab wa Alsidalh be AlMammlakh Alarabeih ALSuaidih’ ‘The Development of Saudi Arabian Medical and Pharmaceutical Professions’ Regulations’ p. 74-78.

⁶⁰ *Ibid.* p. 74-78.

⁶¹ M AlBar and H Pasha *Contemporary Bioethics Islamic Perspective* p. 112-113.

⁶² D Atighetchi *Islamic Bioethics: Problems and Perspectives* p. 52.

consent instead of her consent or if the decision should only be made by the woman herself.⁶³

Abu-Aisha has argued that until the middle of the 1980s in Saudi Arabia:

‘There (was) a general misconception amongst the medical professional that a mature mentally sound woman (had) no right to give consent for medical procedures necessary for her in Saudi Arabia. Usually when invasive medical procedures (were) necessary for the management of diseases affecting a woman, a male guardian (was) sought to sign the consent form.’⁶⁴

The author suggests that there was a misunderstanding and misrepresentation among medical staff who, generally, did not accept the idea of adult competent women’s rights to consent to medical treatment which seems, in some cases at least, to have been based on the view that there was no clear legal principle to support that. Hence, as a result of the prevailing confusion and disputes regarding the requirements for both male and female patients’ consent, the Minister of Health (MoH) in 1983⁶⁵ submitted the legal question to the King’s office in order for the GPSRI⁶⁶ to study the matter based on Islamic *Sharia*’s sources. The GRPSI was asked to establish a legal principle regarding competent adult male or female patient consent in relation the issue that ‘...doctors face when patients or those in charge of them refuse to have certain surgeries performed on them and the consequences of that.’⁶⁷ The GPSRI had to set a legal principle; so, it considered the legal question as follows:

‘The Council, having studied the matter through consultation and exchange of opinions, unanimously decided that it is not permissible to operate on patients without their permission provided that the patient is pubescent [adult] and sane [competent], whether this patient is a male or a female. If the patient is not of age [not adult] or insane [incompetent], then the permission of his/her...guardian must be obtained.’⁶⁸

As has been mentioned in Chapter two, although GPSRI is not a regular part of the Saudi Arabian legislative bodies, it is always involved in medical issues such as this one about patients’ consent. This GPSRI declaration established the legal principle for obtaining a

⁶³ P Halligan ‘Caring for Patients of Islamic Denomination: Critical Care Nurses’ Experiences in Saudi Arabia’ (2006) 15 *Journal of Clinical Nursing* 1565-1573 p. 1571.

⁶⁴ H Abu-Aisha ‘Women in Saudi Arabia: Do they not have the Right to Give Their Own Consent for Medical Procedures?’ (1985) 5 *Saudi Medical Journal* 74-77 p. 75

⁶⁵ That was in 14/3/1404 A.H. [19/12/1983]. GPSRI declaration no 119 in 1984 at <http://www.alifta.net/Fatawa/FatawaChapters.aspx?languagename=en&View=Page&PageID=175&PageNo=1&BookID=17> (accessed 01/07/2015).

⁶⁶ See GPSRI role for setting law in Saudi Arabia discussed in Chapter two.

⁶⁷ GPSRI declaration no. 119 in 1984.

⁶⁸ *Ibid.*

patient's consent, which was adopted in 1984 by the MoH as the legal approach to obtain consent to treatment.⁶⁹

The GPSRI declaration has therefore been legally binding since that time⁷⁰ and this approach is now a part of LPHP2005 and CEHP2013. LPHP2005 has declared that '[n]o medical intervention may be performed except with the consent of the patient, his representative or guardian if the patient is legally incompetent.'⁷¹ LPHP2005 has recognised as an exception to the general legal requirement for obtaining a patient's consent

'...in cases of accidents, emergencies or critical cases requiring immediate or urgent medical intervention to save the patient's life or an organ thereof or to avert severe damage that might result from delay, where the timely consent of the patient, his representative or guardian is unattainable.'⁷²

In those cases, doctors should intervene immediately and there is no need to obtain consent. Further, doctors in such cases are not allowed by the law to decline intervening or treating.⁷³ CEHP2013 in terms of recognising patients' rights to consent has considered the issue in more detail and contains additional requirements that LPHP2005 did not mention. CEHP2013 has stated that:

'The adult conscious patient's permission (consent) should be sought (whether the patient is male or female), or from his/her representative in case the patient is not competent to decide, before any medical or surgical intervention.'⁷⁴

Moreover, CEHP2013 has indicated that the consent must be in written form, if the medical procedure '...includes possible risks, like surgical operations, biopsy, or similar procedure'.⁷⁵ It is important to remember that CEHP2013 is not only an ethical guideline, but is also legally binding.⁷⁶

⁶⁹ H Abu-Aisha 'Women in Saudi Arabia: Do They not Have the Right to Give Their Own Consent for Medical Procedures?' p. 75

⁷⁰ The same statement was part of the Law of Practicing Medicine and Dentistry Professions 1989. This Law was cancelled by LPHP2005 in 2005.

⁷¹ LPHP2006 article 19.

⁷² Ibid. See also CEHP2013 chapter 14 (5) at 47 which ordered a doctor to '[s]tart of medical intervention without waiting for permission of the patient or guardian; this is conditional that the patient may be exposed to imminent death or severe harm, or there is high probability for such harm.'

⁷³ LPHP2005 article 16.

⁷⁴ CEHP2013 chapter 2(C) p. 17.

⁷⁵ Ibid. chapter 2(C)4 p. 17.

⁷⁶ LPHP2005 article 5, section, 2 in the executive regulation.

In terms of respecting patients' choices, LPHP2005 has placed legal duties on doctors to respect patients' choices.⁷⁷ However, it has included some limitations on patients' rights to choose, since choices should be respected only as long as they are not in conflict with either Islamic *Sharia* or Saudi Arabian laws.⁷⁸ CEHP2013 has also recognised patients' right to consent,⁷⁹ but it has said nothing about respect for their choices. However, as LPHP2005 has superior legal status to CEHP2013, it can be said that the same limitations to patients' choices are applicable. Therefore, in terms of respecting patients' consent and choices, it is clear that the Saudi Arabian medical regulations have to some extent already adopted a legal standard based on Islamic *Sharia*'s religious and ethical principles, which were explored in the Chapter two.

It should also be noted that, nonetheless, neither LPHP2005 or CEHP2013 mention that doctors should not exceed the patient's consent by performing other treatment that is beyond what the patient has consented to, or whether the patient can withdraw his/her consent (saving the case of *Wajib* treatment). Muslim scholars agree that doctors should not exceed the limit of consent except under the principle of necessity, and that the patient can withdraw his/her consent.⁸⁰ This view is applicable in Saudi Arabian medical law because, if there is no reference in Saudi Arabian written law to a matter, Islamic *Sharia* general principles are applicable. This view by Islamic *Sharia* is similar to the English law view discussed in Chapter three. However, I would argue that such issues should be addressed by LPHP2005 to give more protection to patient consent and autonomy. As this thesis is limited to the issue of information disclosure standard, it will not further discuss these issues.

Having set out the legal principles of consent law in Saudi Arabia, what follows will discuss the protection of patients based on criminal and civil laws.

3. Legal consequences of proceeding without a competent adult patient's consent
Consent to or refusal of medical treatment is fundamental to the law regulating medical treatment and doctors' professional conduct in Saudi Arabia.⁸¹ Muslim scholars have appreciated the need for consent as its existence not only protects competent adult patients

⁷⁷ Ibid. article 5 section, 1 in the executive regulation executive stated that: 'Healthcare professionals must respect patients' choices in accordance with Islamic *Sharia* and law.'

⁷⁸ Ibid.

⁷⁹ CEHP2013 chapter 2(C) p. 17.

⁸⁰ M AlShanqeeti, *Ahkam Algerhah Altibeh wAlather Almotrbh Aliha. (Rulings of Medical Surgeries and Their Consequences)*. p. 167.

⁸¹ LPHP2006 article 19.

from offences and reckless acts against them by others, reserving the right to decide for the patient alone, but it also enables doctors to practise their profession legally, as valid consent may render them immune from legal liability for their actions.⁸² The legal consequences of doctors breaching their obligations will be considered in more detail. Generally, in the case of emergencies doctors are not liable for treating patients without consent and their actions are justified based on the principle of necessity, as one of Islamic *Sharia*'s principles has recognised that '[n]ecessities make forbidden things canonically harmless'.⁸³ This was enacted in LPHP2005, which allowed doctors to treat or intervene with no consent in the kinds of cases mentioned earlier.⁸⁴ However, apart from such cases, dealing with a person's body requires a valid consent. Treating patients without a valid consent may attract either the application of the crime of assault or civil liability as will be discussed below. As criminal liability and prosecution are rare in the case of doctors, in the following (as in Chapter three) I will only briefly discuss this, before considering civil liability in more detail.

3.1. Criminal liability

According to Islamic *Sharia*, for an action to be considered as a crime, three conditions must be met. These conditions in brief are; (1) the defendant must be alive with full mental capacity, (2) the defendant must have voluntarily intended the action and the result and there must be a causal link between them, and (3) the action must be criminalised under Islamic *Sharia*.⁸⁵

Under Islamic *Sharia* criminal law, there are three types of crimes and punishments: (1) *Hudod* (capital offences or crimes against Allah). These are fixed crimes and punishments that have been stated by primary sources of Islamic *Sharia*, so neither the punishments nor the crimes are able to be dropped or waived if the defendant's action has been proved with sufficient certainty.⁸⁶ *Hudod* (*Hadd* singular, *Hudod* plural) include only seven crimes and punishments; adultery, apostasy, drinking alcohol, slander, theft, highway robbery, and sedition.⁸⁷ As *Hudod* crimes and punishments are not related to the thesis's issues and are rarely likely to be committed in the medical context, they will not be further discussed.

⁸² Q AlMubarak *AlTadawi wa AlMasoeilih AlTabieh fa Alshria AlIslamia (Treatment and medical liability based on Islamic Sharia)* p. 197.

⁸³ The Mejlle Being an English Translation of Majhallah el-Ahkam-i-Adliya and a Complete Code on Islamic Civil Law. article 21.

⁸⁴ LPHP2005 article 19.

⁸⁵ A Bahnassi 'Criminal Responsibility in Islamic law' in C Bassiouni (ed.) *The Islamic Criminal Justice System* (Oceana Publication INC 1982) 171-191 p.171-172.

⁸⁶ A Badawi *The Concise Presentation of the Fiqh of the Sunnah and the Noble Book* p. 575-604

⁸⁷ M Abdulfattah *Simplified Islamic Jurisprudence Based on the Quran and the Sunnah* Vol 2 p. 970-986

(2) *Qisas* and *Diyyah* (crimes against a person) are offences where the punishment should fit the crime and the defendant has the intention to act. There are specific types of punishments that are regarded as appropriate for particular kinds of acts. Examples would be the crime of murder, which has the death penalty as punishment, and the crime of intentional injury or damages to a person and which requires *Qisas* or the payment of *Diyyah* blood money (the amount is set by the law).⁸⁸ However, in

Qisas and *Diyyah* crimes, the victim or his/her family (not the government or the court) have the right to decide whether the offender should be charged or not. After the case is brought to the court by the Public Prosecutor, if the victim is still alive then he/she can abolish the charge (courts cannot do that without the victim's approval) for the offence and forgive the offender either in return for the payment of compensation or without seeking compensation; if the victim has died, the family has the same right to do so.⁸⁹ Thus, the charge of the main crime can be abolished by the victim, but the courts have to hand down a discretionary penalty for the defendant in the public interest, because the defendant breached the law. On the other hand, if the victim (or his/her family, if the victim had murdered) pursue the case, the case will be brought to a criminal court by the Public Prosecutor. If after the trial the defendant is found guilty, the sentence will be imposed by the authority.⁹⁰ If the defendant is innocent, the case will be closed.

(3) *Tazir* (discretionary punishments). For such crimes, punishments are left to the legislative authorities or judges to decide what is suitable depending on the crime's severity and the criminal's actions and past behaviour. *Tazir* includes some crimes like bribery and there are different kinds of punishment, such as imprisonment, fines, verbal warning and so forth.⁹¹ Courts can waive the charge, with the victim or his/her family's approval, because these crimes are regarded as being more than *Qisas* and *Diyyah* crimes against the public interest.⁹² To establish a doctors' criminal liability, the Public Prosecutor has to prove that the doctor had criminal intention. The case will be heard by a criminal court not SMPs

⁸⁸ M Lippman, S McConville and M Yerushalmi *Islamic Criminal Law and Procedure* p. 38-39

⁸⁹ M Abdulfattah *Simplified Islamic Jurisprudence Based on the Quran and the Sunnah* Vol 2 p. 956-957

⁹⁰ LCP2013 stated that '1. Judgments imposing death, stoning, amputation qisaas for murder or other than death, shall only be executed pursuant to a Royal Order to be issued by the King or his authorized representative. 2. Representatives of the Administrative Governor, the Court, the Bureau of the Promotion of Virtue and Prevention of Vice, and the police shall witness the execution of the judgment involving death, stoning, amputation, flogging or qisaas for murder or other than murder. The executive regulations of this law shall determine the procedures of their work.' Article 227 sections 1 and 2.

⁹¹ M Abdulfattah *Simplified Islamic Jurisprudence Based on the Quran and the Sunnah* Vol 2 p. 958-259.

⁹² M Lippman, S McConville and M Yerushalmi *Islamic Criminal Law and Procedure* p. 52-53.

because that is out of their jurisdiction.⁹³ It is rare for the required criminal intent to be established, because the doctor is usually seeking to provide treatment to improve patient health not to cause him/her injury, nor to do something against his/her faith.⁹⁴

To conclude the discussion, it seems that both Islamic *Sharia* principles and Saudi Arabian law have agreed that it is very rare for a doctor to have a criminal motive, because doctors aim to treat patients and promote their health, not the opposite.⁹⁵ Thus criminal prosecution is difficult as doctors normally will not treat without any consent at all or intend to cause bodily harm.⁹⁶ Thus, similar to English law, criminal prosecutions of doctors in Saudi Arabia are extremely rare. Finally, it should be noted that LPHP2005 does not consider doctors' breaching of consent law as a crime of assault. Thus if doctors do not obtain the patient's consent, or treat where there has been a refusal of consent, they either will be fined or imprisoned or both for breaching LPHP2005.⁹⁷

3.2. Civil liability (*AlDaman*)

According to Islamic *Sharia*, there are three conditions that must be met to succeed in an action under civil law. These conditions in brief are: (1) *Altaadi* (breach of the duty) which means the person's action is not in accordance with what has been stated by the Islamic *Sharia* as appropriate, the custom or the standard practice, (2) *AlDarar* (injury or damage) which means causing damage to another as a result of the action and (3) *Alifdha* (causal link) which means that the result occurred as a result of the action.⁹⁸ I will consider these conditions in more detail later in this Chapter when I discuss the issue of the consequences of the failure to disclose information to the patient.

Islamic *Sharia* considers the profession of practicing medicine as a noble occupation, because doctors are providing comfort and help to reduce patients' suffering and pain by treating them.⁹⁹ This is the kind of humanitarian service that society in general and patients

⁹³ LPHP2005 articles 34 sections 1 and 2.

⁹⁴ A Oudah *Altashree Aljanei Alislami (Criminal Law of Islam)* (Dar Alhadith, 2009) Vol 1 p. 332-333 and M Abo Zhrhah *Aljeremah wa Aloqabah fe Alfeqh Allislami -Alaqabah- Crimes and Punishments in Islam – Crimes-* (Dar Alfaker Alarabei 1998) p. 323 (Arabic).

⁹⁵ M AlShanqeeti, *Ahkam Algerhah Altibeh w Alather Almotrtbh Aliha. (Rulings of Medical Surgeries and Their Consequences)*. p.365.

⁹⁶ Q AlMubarak *AlTadawi wa AlMasoeilih AlTabieh fa Alshria Alislamia (Treatment and Medical Liability Based on Islamic Sharia)* p. 150-152. See also, M Hanna *AlNadrieh AlAlamh La alMasowliroh alTabieh (the General Theory of Medical Liability)* (1sted Dar Alfiker AlJamee 2011) p. 93. (Arabic).

⁹⁷ LPHP2005 article 28 section 7.

⁹⁸ A Masry *Jrageem Alataba wa Almsoeilih Aljenaeeih wa Almadneeih en Alakta Altabeih beain AlShraia wa Alqaon (Doctors' Crimes and the Criminal and Civil Liabilities for Medical Negligence between Sharia and Law)* (1sted DarAlaloom 2011) p. 195 (Arabic).

⁹⁹ For example, CEHP2013 p. 10-12.

in particular appreciate. However, this is not to say that doctors should be absolved from civil liability when damage occurs as a result of their actions. Thus, it is important to consider whether, where injury is sustained by a patient as a result of medical care, any civil liability is incurred, for which patients should be awarded damages.

It should be noted that, in the context of civil liability, Islamic *Sharia* and LPHP2005 have considered the total absence of consent or invalid consent (information or risk has not been disclosed) as the same. However, LPHP2005 considers that failing to obtain consent or treating without consent is against the law as it is contrary to Islamic *Sharia* and therefore against standard practice. However, in civil liability, a doctor does not have the criminal motive to intend the action and the result, but the action is due to the doctor's mistake or negligence, so the case here will be heard by SMPs. Thus, the following discussion will deal with the issue of civil liability for an injury to the patient regardless of the amount or type of information provided before consent was given.

3.2.1. Proficient doctors who treat the patient with consent

Under this category, the proficient doctor is treating in accordance with the acceptable standard of professional practice and has obtained the competent adult patient's consent. There are two possibilities under Islamic *Sharia* law and LPHP2005:

(1) If there was injury, but this was not a result of the doctor's error or negligence, the doctor should not be held liable because a valid consent had been obtained; the doctor made an effort to treat the patient and the doctor has not exceeded the acceptable practice of the profession.¹⁰⁰ As the holy *Quran* states in translation that: 'There is no way to blame those who are doers of good, for God is forgiving and kind.'¹⁰¹ Therefore, what the doctor is doing is undertaking humanitarian behaviour and thus he should not be blamed for damage that was beyond his/her control;¹⁰² as a result, the patient should not be compensated.¹⁰³

(2) If the injury was a result of the doctor's error, the doctor should be held liable in civil law (*Daman*) for the injury and he/she has to pay compensation to the patient or his/her inheritors if the patient died.¹⁰⁴ This is regardless of whether the doctor has obtained consent

¹⁰⁰ M Ibn Qayyim Aljauziyah, *Healing with the Medicine of the Prophet* p. 125.

¹⁰¹ The holy *Quran* in translation (CH9:91)

¹⁰² P Kassim 'Medical Negligence in Islamic Law' (2006) 20(4) *Arab Law Quarterly* 400-410 p. 405.

¹⁰³ LPHP2005 article 27.

¹⁰⁴ *Ibid.*

and acted in accordance with the standards of the profession – the doctor has caused harm and should be liable to pay compensation.¹⁰⁵

3.2.2. Proficient doctors who treat the patient without consent

Under this category, proficient doctors are treating in accordance with the acceptable standard of professional practice, but without having obtained the competent adult patient's consent and the case is not an emergency.¹⁰⁶ In this case, there are two views:

(1) The less common view holds that a doctor should not be held liable for civil liability (*Daman*), because although he/she treated without consent or in the face of the patient's refusal, he/she was acting as a responsible professional and in a good faith to treat and cure the patient's illness. As his/her intention was to cure the patient not to cause him/her an injury, the doctor should not be liable.¹⁰⁷

(2) The most common view, which is adopted by LPHP2005 is to hold the doctor liable for negligence, because the doctor has no authority to treat a competent adult patient without his/her consent, regardless of what professional practice on the matter is.¹⁰⁸ Further, the doctor by treating the patient has caused him/him pain and injury which he/she did not consent to or want, and the patient's bodily integrity has been breached. Thus, the doctor should be held liable in civil law (*Daman*), and pay compensation (civil remedy) to the patient for the injury, or his/her family if he/she died.¹⁰⁹

For the public interest which arises as an additional issue in the context of a civil action to treat the patient without consent or with the patient's refusal,¹¹⁰ the doctor in question can be fined (to be paid to the treasury) or imprisoned or both by SMPs for breaching LPHP2005.¹¹¹ Additionally, SMPs can issue a warning or fine or suspend the doctor's licence for the disciplinary liability.¹¹² This would be the case unless the doctor was required

¹⁰⁵ M Ibn Qayyim Aljauziyah, *Healing with the Medicine of the Prophet* p. 125.

¹⁰⁶ Doctors can treat in emergency case without consent under the principle of necessity.

¹⁰⁷ M Ibn Qayyim Aljauziyah, *Healing with the Medicine of the Prophet* p. 125

¹⁰⁸ M AlShanqeeti, *Ahkam Algerhah Altibeh w Alather Almotrtbh Aliha. (Rulings of Medical Surgeries and Their Consequences)*. p. 362.

¹⁰⁹ Ibid. p. 368.

¹¹⁰ When the patient's obligation is *Makroh* (blameworthy) or *Mandob* (praiseworthy) or *Mobah* (indifferent) to consent to or refuse treatment.

¹¹¹ LPHP2005 articles 19 and 28 section 7.

¹¹² Ibid. articles 31 and 32 sections 1,2 and 3.

not to respect the patient's wishes because they would be in breach of the regulations and/or Islamic *Sharia*.

I have discussed in Chapter three in relation to seeking valid consent under English law the distinction between different types of civil action for inadequate information disclosure: battery and negligence. Although Saudi Arabian law would deal with both of these situations as *Daman*. I would argue that under Islamic *Sharia* and Saudi Arabian medical law there would also be different ways for the patient to establish that the consent was not legally valid. These would include the claim that the patient was not competent to consent. Another possible approach for the patient is to claim that he/she was coerced or under undue influence to accept the treatment. Lastly, there is the more significant issue for this thesis, which is the issue that the patient has not been given adequate information regarding the nature of the treatment or procedure. As discussed, in Saudi Arabian law the same action would be used to seek damages whether there was no consent at all or the failure to provide information related to risks, benefits and alternatives. Thus, in the following the thesis will discuss the requirements of a valid consent.

3.2.3. Requirements for a legally valid consent

Similar to what has been discussed regarding valid consent in English law in Chapter three, for consent to be legally valid in Saudi Arabia it must have three main elements, namely: 1. Competence and capacity, 2. Voluntariness, and 3. Information, as CEHP2013 has considered all these points, although surprisingly LPHP2005 does not mention these issues.¹¹³ Therefore, to consider a competent adult patient's consent to be legally valid it must meet the following conditions:

A. Competence and capacity (*AlAhleiah*)

As set out in the Introduction, the thesis's scope is limited to competent adult patients. However, it is useful to explain what that concept means in Saudi Arabia. Based on Islamic *Sharia*, the age of adulthood can be identified by either the physiological signs (pubic hair in both sexes, wet dreams for boys, periods for girls),¹¹⁴ or reaching a specific age, which differs from one school of thought to another,¹¹⁵ but the majority of Muslim scholars have agreed

¹¹³ CEHP2013 chapter 2(C) 1,2 and 3 p. 17.

¹¹⁴The Mejjelle Being an English Translation of Majhallah el-Ahkam-i-Adliya and a Complete Code on Islamic Civil Law. article 985.

¹¹⁵M Almodfar *Nadriet AlAqed and Aleradh AlMonfradh Dersah Qnownieh Moqarnh be Ahkam Alshria Alslamieh (the Theory of Contract and Individual's Will based on Comparative Laws and Islamic Sharia)* (Dar Hafad, 2002) p. 166-167(Arabic).

that the age should be no less than 15 years, based on the Islamic calendar,¹¹⁶ unless one of the physiological signs has appeared before the completion of the 15 years.

However, Islamic *Sharia* assesses competence by two conditions; that the person must have: (1) reached the age of marriage (adulthood) and (2) proper judgement, as interpreted from the holy *Quran*,¹¹⁷ which declares in translation, ‘and try orphans (as regards their intelligence) until they reach the age of marriage; if then you find sound judgement in them, release their property to them...’.¹¹⁸ Saudi Arabian law applies the same method to assess capacity, with the two elements (adult age and soundness of judgement) presumed for everyone 18 years or over in the absence of proof of incapacity.¹¹⁹ Apart from this general legal presumption about capacity, CEHP2013 has stated clearly that: ‘The patient should be able to understand and appreciate the information that he/she has been provided so that he/she decides with full consciousness, awareness and conviction.’¹²⁰ This shows the recognition that a valid consent to treatment requires that the patient should have the capacity to understand and where the patient is not deemed to have adequate capacity, others may be authorised to make a decision for them.

B. Voluntariness (*AlEradah*)

Again, what has been discussed about the importance of voluntariness¹²¹ under English law seems to be similar to Islamic *Sharia* and Saudi Arabian law. As a general principle, a person must be free to choose and decide, and his/her right to do so must be protected in accordance with Islamic *Sharia*.¹²² Accordingly, for a patient’s consent to be legally valid, it is essential that it is given voluntarily and freely. This is referred to in CEHP2013, which states that ‘the patient’s consent should be made voluntarily without pressure or coercion.’¹²³ There are a number of issues that are relevant to this issue.

Coercion (*Allkrah*)

Coercion (*Allkrah*), based on Islamic *Sharia*, ‘... is without right to compel a person to do a thing without his consent, by fear.’¹²⁴ Therefore, when a person is under a realistic grave

¹¹⁶ Ibid. p.167.

¹¹⁷ Ibn Kathir *Tafsir Ibn Kathir (The Interpretation of the Holy Quran)* p. 443.

¹¹⁸ The holy *Quran* (CH4:6).

¹¹⁹ The Saudi Arabia Nationality Law 1954 article 1(C) in the Executive Regulation 2005. (Arabic).

¹²⁰ CEHP2013 chapter 2(C) 3 p. 17.

¹²¹ The discussion is for a competent adult patient only as the thesis is only limited to that category.

¹²² M AlShanqeeti, *Ahkam Algerhah Altibeh w Alather Almotrtbh Aliha. (Rulings of Medical Surgeries and Their Consequences)*. p. 167.

¹²³ CEHP 2013 chapter 2(C) 2 p. 17.

¹²⁴ The Mejlle Being an English Translation of Majhallah el-Ahkam-i-Adliya and a Complete Code on Islamic Civil Law. article 984.

threat of harm or loss of life, in that state his/her free will to choose to do or say something is controlled.¹²⁵ However, for coercion to be realistic there are four conditions that should be met:(1) the person making the threat must be able to fulfil his/her threat,¹²⁶ (2) the compelled person must be afraid and believe that the threatener will fulfil his/her threat,¹²⁷ (3) the compelled person must do what he/she has been ordered to do in the presence of the threatener¹²⁸ and (4) the tool or the degree of threat must be so great that the person is compelled to do or say something that he/she does not want to.¹²⁹

Hence, it can be argued that coercion is an action by another that would affect a competent adult patient's free choice to consent to or refuse treatment.¹³⁰ So, if there is a piece of evidence which demonstrates that he/she has been forced to give his/her consent, the consent can no longer be accepted as legally valid.¹³¹

Abuse or influence (*Allstglal*)

Allstglal is the act of abusing a weakness in person's character or his/her need to obtain something to get him/her to perform an action that he/she does not want to do, or to illegally obtain a benefit from him/her.¹³² The abuse may take different forms such as to abuse the patient's need for care or treatment. LPHP2005 has stated that a doctor '...may not request, accept or take a commission or reward; nor may he receive any benefit in return for promoting or strictly prescribing certain medications, or equipment or directing patients to a particular pharmacy, hospital, laboratory or the like.'¹³³ Other forms of abusing the patient's need to be treated might be to ask him/her to consent to participate in medical research, that he/she does not want to be in, but because he/she will be paid or treated for free. CEHP2013 states that: 'It is not permissible to...[obtain]...consent by using pressure, coercion, or by abusing their [patients] need of money or treatment.'¹³⁴

¹²⁵ M Almodfar *Nadriet AlAqed and Aleradh AlMonfradh Dersah Qnownieh Moqarnh be Ahkam Alshria Alslamieh (the Theory of Contract and Individual Will based on Comparative Laws and Islamic Sharia)* p. 132.

¹²⁶ The Mejlle Being an English Translation of Majhallah el-Ahkam-i-Adliya and a Complete Code on Islamic Civil Law. article 1003.

¹²⁷ *Ibid.* article 1004.

¹²⁸ *Ibid.* article 1005.

¹²⁹ M Almodfar *Nadriet AlAqed and Aleradh AlMonfradh Dersah Qnownieh Moqarnh be Ahkam Alshria Alslamieh (the Theory of Contract and Individual Will based on Comparative Laws and Islamic Sharia)* p. 134.

¹³⁰ M AlShanqeeti, *Ahkam Algerhah Altibeh w Alather Almotrtbh Aliha. (Rulings of Medical Surgeries and Their Consequences)*. p. 167.

¹³¹ M Albar and H Pasha *Masoleet ATabeeb bein AlFqih wa AlCanoon (The Doctor's Liability Between Fiqh and Law)* p. 34

¹³² M Almodfar *Nadriet AlAqed and Aleradh AlMonfradh Dersah Qnownieh Moqarnh be Ahkam Alshria Alslamieh (The Theory of Contract and Individual Will based on Comparative Laws and Islamic Sharia)* p. 148.

¹³³ LPHP2005 article 12.

¹³⁴ CEHP2013 chapter 11(A) 9(d). p. 43.

Another example of abuse recognised by CEHP2013 is that the doctor should never put ‘any pressure on the patient to have such photograph[ic] (imaging) or recording [made] and never coerce the patient to accept [that].’¹³⁵ CEHP2013 has also recognised that a doctor should not refuse to treat or influence a patient to do something that he/she does not want to do as a result of a ‘...previous professional relationship [that] has become an emotional affair with either a current/past patient or one of the patient’s family members.’¹³⁶

Another interesting facet of abuse for this thesis is that relating to knowledge and information disclosure. CEHP2013 has recognised that in terms of medical information and knowledge patients may be ignorant about the benefits and risks of medical treatment. Thus, patient’s ignorance can be abused by ‘...misleading them by claiming the ability to perform diagnostic or therapeutic procedures which have no scientific evidence basis.’¹³⁷ Hence, because of doctors’ medical knowledge, they must refrain from abusing the ignorance of their patients and they should provide them with the right and relevant information they need or require.¹³⁸ Abusing the patient’s lack of knowledge and not providing sufficient information or misleading them might affect their ability to give their consent voluntarily.¹³⁹

Mistake (*AlKhata*)

AlKhata, simply, is the state of an erroneous belief that some facts are true and, based on that misunderstanding, a person makes or refuses to make an agreement. Accordingly, a person’s choice cannot be considered to be effective or true as his/her consent or refusal is based on non-genuine facts.¹⁴⁰ For a patient’s consent to be legally valid, it must reflect his/her will, and to achieve that CEHP2013 has stated that a patient should be able to acknowledge and understand the information given in order to make his/her decision.¹⁴¹ A patient’s decision should be built on true information about his/her health conditions or the course of the treatment and medication that his/her case requires, so doctors must avoid gaining patients’ consent by misinforming them about the reality of the treatment’s efficiency or that the illness can be cured.¹⁴²

¹³⁵ Ibid. chapter 2(F) 3.p. 21.

¹³⁶ Ibid. chapter 7(C) 3 p. 31.

¹³⁷ Ibid. chapter 10(C) 5 p. 39.

¹³⁸ Ibid. chapter 2(C) 1 p. 17.

¹³⁹ Ibid. chapter 10(C) 5 p. 39 and chapter 2(C) 1 p. 17.

¹⁴⁰ M Almodfar *Nadriet AlAqed and Aleradh AlMonfradh Dersah Qnownieh Moqarnh be Ahkam Alshria Alslamieh (the Theory of Contract and Individual’s Will based on Comparative Laws and Islamic Sharia)* p. 117.

¹⁴¹ CEHP2013 chapter 2(C) 2 p. 17.

¹⁴² Ibid. chapter 10 (C) 5 p. 39.

A form of mistake is regarding the doctor's qualification and licence, so if the patient thought that the doctor who will treat him/her is qualified and licensed but he/she is not, then his/her consent to treatment is not legally valid, because LPHP2005 banned the practice of medicine for those who are unqualified or unlicensed or both.¹⁴³ LPHP2005 further has put a legal duty on doctors and forbids them to '...employ unlicensed healthcare professionals or provide assistance to any person illegally practicing a healthcare profession...' ¹⁴⁴ Therefore, if the patient consents because he/she mistakenly thought that the doctor still holds a valid qualification or licence, that consent is vitiated and invalid and the doctor should be held liable both criminally and civilly.¹⁴⁵ On the other hand, if the patient knows that the doctor is unqualified or unlicensed, but nonetheless he/she consented, the patient's consent can be regarded as a valid consent; consequently, the doctor should not be held civilly liable, as he/she did not deceive the patient about his/her current qualification or licensing.¹⁴⁶ The views of Islamic *Sharia* and Saudi Arabian law consider the patient's consent as a defence to civil action if the patient consented knowing that the doctor was unlicensed or unqualified, although the doctor may still be subject to disciplinary liability for unlawful conduct.¹⁴⁷

To conclude the discussion of this element of consent, it can be said that voluntary consent must be free from coercion, abuse and mistake. Although the legal systems of England and Saudi Arabia derive from different backgrounds, they do share much common ground.

The last element of a valid consent is of course the one of greatest significance to this thesis so it will be discussed below in depth.

C. Adequate information disclosure (*AlTabsser*)

The element of a decision being based on sufficient information to a valid consent is obviously important.

C.1. Information disclosure and the current practice under Saudi Arabian medical law

The main issue of this thesis is to investigate the current practice regarding the standard of care in information disclosure in respect of medical treatment in Saudi Arabia. In addition, it is to argue that this is inadequate in terms of protecting patient autonomy, in terms of gaps in the current law and the adequacy of the standard of care. It is therefore necessary to

¹⁴³ LPHP2005 article 28 sections 1 and 2.

¹⁴⁴ *Ibid.* article 14 section A.

¹⁴⁵ See the discussion above.

¹⁴⁶ M Ibn Qayyim Aljauziyah, *Healing with the Medicine of the Prophetp.* 126.

¹⁴⁷ LPHP2005 article 28, sections 1,2, and 4.

examine further what that law is. The Islamic *Sharia* and Saudi Arabian legal principles have been set out in this Chapter, as have the present medical laws on the general principles of consent to medical treatment as stated in LPHP2005 and CEHP2013, though this is perhaps not as clear as it might be. In the following discussion, I will start by presenting the current application of Saudi Arabian medical law in the civil law context. Then I will discuss the conditions for establishing doctors' liability in negligence, including the current standard of care in information disclosure. Based on this discussion, I will conclude that there is both some lack of legal coverage of specific issues and that the standard of care should be addressed more clearly in order to better protect patient autonomy. As noted, this would require legislation. Thus, I will propose recommendations as to how Saudi Arabian medical law can learn from the English law experience in developing better legal recognition of respect for patients' autonomy and develop this without creating conflict with Islamic *Sharia*. My view, suggestions and recommendations will be presented in the Concluding Chapter.

In order to understand how SMPs have interpreted and applied the laws, it is worth considering SMPs' role and formation first. LPHP2005 has established special medical courts of law named SMPs.¹⁴⁸ Their jurisdiction is limited to medical law litigation, specifically any case that is related to the violation of LPHP2005 or CEHP2013 or any '...cases of medical malpractice leading to death, damage of an organ or loss of total or partial use thereof...' ¹⁴⁹

SMPs are the current first-instance medical courts of law and there are many SMPs around the country.¹⁵⁰ Each SMP is comprised of a judge from the *Sharia* Court of Appeal as the head of the panel, a counsellor (lawyer) from the Ministry of Health, a professor from a medical school and two expert doctors.¹⁵¹ However, if the case involves a pharmacy error or if the defendant is a pharmacist, two additional members must join the SMP – a professor from a pharmacy school and an expert pharmacist.¹⁵² Further, the SMP has the right to appoint additional experts if that is needed.¹⁵³ The decision in SMPs is taken '...by a majority vote, provided the majority includes the judge...' ¹⁵⁴ The parties can appeal to the regional

¹⁴⁸ *Ibid.* article 33 section A.

¹⁴⁹ *Ibid.* article 34 sections 1 and 2.

¹⁵⁰ There are more than 13 SMPs in the country.

¹⁵¹ LPHP2005 article 33 section A (1,2,3 and 5).

¹⁵² *Ibid.* sections A (4 and 6) and B.

¹⁵³ *Ibid.* section E.

¹⁵⁴ *Ibid.* article 35.

Administrative Court of Appeal in the Board of Grievance within sixty days of being officially informed about the judgment.¹⁵⁵

C.2. An overview

Based on Islamic *Sharia*, in order for patients to give valid consent they should receive adequate information to enable them to make a clear decision to consent to or refuse medical treatment, and must not be forced or misled in any way, as otherwise consent is invalid.¹⁵⁶

Although the general principles of consent to medical treatment in Saudi Arabian law have been discussed, and it is clear that civil liability can result from a failure to comply with the requirements to obtain a valid consent, the particular issue of information disclosure that is required for a consent to be valid has not yet been addressed. I would argue that there is currently confusion regarding the principle of law that governs the matter of information disclosure and the standard of how much information or risks should be disclosed to patients in both LPHP2005 and CEHP2013. Some ideas about how to provide medical information to patients or warn them about risks can be gleaned from consideration of LPHP2005, but they are presented in a way that does not provide plain rules on these issues. Furthermore, I would argue that SMPs have not examined the subject in detail, so there is little guidance to be obtained from them or information about how these issues will be interpreted to influence future conduct, whether that is of doctors in seeking consent, patients pursuing litigation or SMPs in imposing penalties. It should be remembered that the doctrine of precedent is not applicable in Saudi Arabia, but nevertheless it must be considered important that there is consistency and clarity in the law in this area. I would suggest that the areas of both information and risk disclosure standards and doctors' liability remain unclear and in need of reconsidering to fill the legal vacuum, as until now there has been insufficient discussion of the subject.

In the following discussion, the thesis will present and discuss the consideration that has been given and deficiencies in relation to information disclosure in the current Saudi Arabian medical laws. After the thesis has highlighted them in this Chapter, in the Concluding Chapter the thesis will present the possible solutions as proposals for law reform.

¹⁵⁵ Ibid.

¹⁵⁶ H Hassan *An Introduction to the Study of Islamic Law* (Adam publisher 2007) p. 344.

C.3. Information disclosure in current Saudi Arabian medical law

I would argue that there is a single article in LPHP2005 that considers the issue of providing patients with information, warning them about risks, the issue of therapeutic privilege and patients' right to not be informed or to waive that right. However, there are several statements by CEHP2013 in relation to information disclosure which I will consider.

In the beginning, I would argue that the duty of doctors to provide patients with health services in general and information disclosure specifically can be understood to be based on the professional standard (prudent doctor standard). LPHP2005 in article 26 has declared that:

‘A healthcare professional governed by this Law [LPHP2005] *shall exert due care in line with commonly established professional standards*’.¹⁵⁷ (Emphasis added).

This application is arguably based on the views of Muslim scholars that have set the basic principle of doctors' potential liability as being that a doctor should not be liable for negligence if he/she has acted in accordance with the reasonable practice of a reasonable medical body of opinion in his/her craft.¹⁵⁸ This view seems similar to what has been discussed in Chapter three, regarding the overruled English law standard of care called the *Bolam* test, which stated that:

‘He [a doctor] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.’¹⁵⁹

Thus, it would appear under this view that in Saudi Arabia a doctor should not be held liable where some doctors would not agree with the approach that he/she applied to treat the patient, as long as the approach is accepted by a body of medical opinion in the craft of medicine.¹⁶⁰

However, as there is no direct reference to the standard of care in medical treatment in the main sources of Islamic *Sharia*, it is then left to Muslim scholars to search for and set one. Thus, some scholars have established the principle of a professional standard based on their

¹⁵⁷ LPHP2006 article 26.

¹⁵⁸ M Ibn Qayyim Aljauziyah, *Healing with the Medicine of the Prophet*, p.125-126, A Yacoub *The Fiqh of Medicine Responses in Islamic Jurisprudence to Developments in Medical Science* p. 112-113, P Kassim ‘Medical Negligence in Islamic Law’ p. 401 and S AlGhazal ‘The Origin of Bimaristans (Hospitals) in Islamic Medical History’ at <http://www.islamicmedicine.org/bimaristan.htm> (accessed 20/12/2014).

¹⁵⁹ *Bolam v Friern Hospital Management Committee* [1957] 1 W.L.R. 582 p. 587.

¹⁶⁰ A Yacoub *The Fiqh of Medicine Responses in Islamic Jurisprudence to Developments in Medical Science* p. 112-113.

understanding and interpretation of the holy *Quran*, which considers in general that if someone is not knowledgeable about a specific skill, he must ask the expert in that field who possess the experience and the qualification to demonstrate what is the proper and acceptable practice.¹⁶¹ Another foundation of the professional standard is based on one of the Islamic *Sharia* legal principles which declared that '[c]ustom is of force',¹⁶² which means that in any argument about the standard of crafts or skills or knowledge, the way to verify that argument is by applying the acceptable custom or method to investigate the case.

I would argue that this view does not mean that there is no room in Islamic *Sharia* and Saudi Arabian medical law to change the standard of care. As I have argued in Chapter two, Islamic *Sharia* and Saudi Arabian medical ethics have acknowledged respect for patient autonomy in their accordance. Thus, the thesis's argument is to say that both the professional standard and the prudent patient standard can be founded in Islamic *Sharia*, but the prudent patient standard can be applied by the law and would give more protection and consideration for respecting and thus protecting patient autonomy. Thus, the thesis recommends Saudi Arabian medical law to adopt it. I will revisit these issues at the end of this Chapter and in the Concluding Chapter.

Despite the current application of the professional standard, based on the conclusion of Chapter two, both Islamic *Sharia* and Saudi Arabian medical ethics seem to accept the thesis's proposed ethical standard of care that requires doctors to provide patients with sufficient and understandable information to respect their autonomy and be self-determining in accordance with Islamic *Sharia*. This standard will be examined against the current practice under Saudi Arabian medical law in the following discussion.

Considering LPHP2005 may appear to recognise the professional standard for all doctors' duties, it is important to consider whether it in fact does apply equally to information disclosure. I would argue article 18 in LPHP2005 is significant here. It has stated that:

'A healthcare professional shall, after explaining the treatment or surgery involved and outcome thereof, alert the patient or his family to the necessity of following the instructions provided and warn them of the consequences of failing to follow said instructions. A physician may, in cases of incurable or life threatening diseases, decide, at his own discretion, whether it is appropriate to inform the patient or his family of the nature of his disease, unless [the doctor

¹⁶¹ R Shaham *The Expert Witness in Islamic Courts: Medicine and Crafts in Service of Law*. (UCP 2001) p. 28.

¹⁶²The *Mejelle* Being an English Translation of *Majhallah el-Ahkam-i-Adliya* and a Complete Code on Islamic Civil Law. article 36.

was] prohibited to do so by the patient or if the patient designates a person to be exclusively informed.’¹⁶³

Article 19 concerns the necessity of obtaining patients’ consent before any medical treatment or operation.¹⁶⁴ Thus, the order position of these articles suggests that article 18 is referring to the idea of providing patients with information and warning them about risks *before* obtaining their consent. If so, article 18 tackles three main issues in relation to information disclosure: first the doctors’ duty to inform the patient, second the notion of therapeutic privilege, and third where the patient does not wish to receive information.

C.3.1. The doctor’s duty to inform

Based on article 18, LPHP2005 seems to recognise doctors’ legal duty to provide information and warn patients of the consequences of not considering it, as it has stated: ‘A healthcare professional shall, after explaining the treatment or surgery involved and outcome thereof, alert the patient or his family [in case of incapacity] to the necessity of following the instructions provided and warn them of the consequences of failing to follow said instructions.’¹⁶⁵

I would argue that article 18 may be interpreted as placing a legal duty on doctors to provide patients with information about their health conditions based on the ‘commonly established professional standards’ set out in article 26 since article 26 appears to apply to all duties owed by the doctor to the patient, as it does not distinguish between diagnosis and treatment and information disclosure.¹⁶⁶ Accordingly, it can be argued that LPHP2005 has recognised the professional standard and that the information that should be given to the patient should be based on what a prudent doctor in the same circumstances would disclose to the patient.

In fact, I would argue that, while this is an interpretation of article 26 of LPHP2005, it conflicts with the need to respect patient autonomy which is also contained in LPHP2005 in article 19, for example. Therefore, to leave the determination of the standard of care to the professionals would undermine the respect for patient autonomy that is recognised by Islamic *Sharia* and Saudi Arabian medical ethics.¹⁶⁷ Therefore, the general professional standard is not suitable for information disclosure and the prudent patient standard is needed instead to properly protect patient autonomy. This will require the standard to be set out

¹⁶³ LPHP2005 article 18.

¹⁶⁴ *Ibid.* article 19.

¹⁶⁵ *Ibid.* article 18.

¹⁶⁶ *Ibid.* article 26.

¹⁶⁷ See Chapter two for further discussion.

clearly in legislation so that the professional standard does not apply to information disclosure, as I will suggest in the Concluding Chapter.

Furthermore, I would argue that neither in article 18 nor elsewhere in LPHP2005 are there given clear statements about other legal aspects of information disclosure including risks that should be disclosed; whether the patient should be told about available alternative treatment; whether the doctor has a duty to seek to ensure that the patient can understand the provided information; how to answer patients' questions. It seems that the doctors' duty to inform based on article 18 is just to impart information, even if that might be with complex medical terms. This, I would argue, shows no consideration or respect for patient autonomy. Therefore, LPHP2005 should be clear and respect the patient's autonomy to be informed in accordance with Islamic *Sharia*. However, article 18 is an obvious example of the lack of clarity from which LPHP2005 suffers as it contains no clear standard of information disclosure and it does not have an answer for the issues I have raised.

Having considered LPHP2005 I will now turn to CEHP2013. As I have stated in Chapter two besides being an ethical guideline for doctors CEHP2013 is legally binding. In fact, it might be considered that CEHP2013 was intended to fill some of the legal vacuums and to clear the confusion that exists in LPHP2005. This is because it is easier to revise CEHP2013 than reforming LPHP2005, as it only needs approval by a governmental Minister. However, as LPHP2005 surpasses CEHP2013, therefore CEHP2013 should be interpreted and understood in the context of the legal duties which LPHP2005 has recognised.¹⁶⁸

It should be noted that in relation to doctors' duty to inform patients, CEHP2013 has not stated what standard of care should be followed. It therefore does not clarify the issue of whether it is appropriate that the standard of information disclosure should be the professional standard as in article 26 of LPHP2005 or whether a different standard should apply that is more protective of patient autonomy. Nonetheless, I would suggest that, as CEHP2013 should be read and interpreted in the context of LPHP2005, thus article 26 of applying the professional standard would be applicable. Thus, I would argue that CEHP2013 has also failed to consider that respect for patient autonomy has its place in Islamic *Sharia*. In this sense, I would argue that clearing LPHP2005 by adopting the prudent patient standard

¹⁶⁸ LPHP2005 article 5.

of care would give more protection to patient autonomy. Such an adoption by LPHP2005 of the prudent standard of care would require CEHP2013 to be in harmony with it.

In response to the issues, I have raised regarding article 18 and the doctor's duty to inform the patient, the thesis will consider to what extent CEHP2013 has clarified some of these questions. CEHP2013 has recognised in Chapter 2(C) 1, that for a patient's consent to be valid,

‘[t]he healthcare practitioner should present enough information in a language that the patient can understand about what he/she [the doctor] will do, and what is required from the patient, the possible consequences of the patient's decisions, as well as potential complications and risks.’¹⁶⁹

Therefore, it seems that CEHP2013 has considered information disclosure in more detail than the LPHP2005. From the above statement by CEHP2013, there are several issues to discuss.

C.3.1.1. The amount of information that doctors should disclose

Chapter 2(C)1 in CEHP2013 has stated that doctors should provide ‘enough information’. This is not stated in LPHP2005. Additionally, CEHP2013 has provided some elements of what ‘enough information’ should include. It should include information about the course and plan of what the doctor is going to perform and instruct the patient to ‘what is required from’ him/her. Further to that the ‘enough information’ should include ‘the possible consequences of the patient's decisions,’ and finally the ‘potential complications and risks’. These last two elements I will discuss under the issues of patient understanding and risk disclosure.

Although CEHP2013 seems to recognise different elements to be included in providing patients with ‘enough information’, I would argue that using the phrase ‘enough information’ can lead to different conclusions. Does ‘enough information’ include only the relevant information a patient needs? Does ‘enough information’ require all information to be disclosed? Who can determine that the information that has been disclosed is ‘enough’? If the LPHP 2005 professional standard in article 26 is applied, then the doctor's failure to provide ‘enough information’ would seem to be judged by the accepted standard of medical practice.

¹⁶⁹ CEHP2013 chapter 2(C)1 p. 17.

Nonetheless, CEHP2013 seems to attempt to clarify the amount of information that should be disclosed, by using the word ‘enough’ and stating what may be included. However, I would argue that CEHP2013 has not cleared up the confusion and the professional standard of care remains applicable; this, I would argue, has led to the same failure by LPHP2005 to give more protection to respect for patient autonomy. Additionally, this conflicts with duties to protect patient autonomy which are also under LPHP2005 and CEHP2013 – and the reform is necessary to give more priority to patient autonomy. This necessary reform for LPHP2005 to depart from the professional standard and adopt the prudent patient standard would provide more recognition of the respect for patient autonomy that is in accordance with Islamic *Sharia*, which seems now to be clearly marginalised by Saudi Arabian medical law.

A further avenue for confusion is created in connection with the CEHP2013 statement regarding the doctors’ duty to reassure patients.¹⁷⁰ CEHP2013 has advised doctors to reassure the patient by providing him/her ‘...with *sufficient clear information* about his/her condition, which would help to reassure and eliminate his/her fears.’¹⁷¹ (Emphasis added).

This statement comes after the statement about obtaining the patient’s consent.¹⁷² Thus, ‘sufficient clear information’ may then refer to additional information that is given to the patient after consent has been obtained, which may refer simply to the doctors’ usual duty to relieve patients’ fears. However, I would argue that CEHP2013 in this respect is ambiguous, because to obtain consent a patient should be provided with ‘enough information’,¹⁷³ whereas to reassure him/her ‘sufficient clear information’ should be given. It seems odd that the requirement for information to reassure the patient seems to be greater than that which is required to obtain his/her consent.

Thus, I would argue that CEHP2013 also has ambiguity and it has not solved the problem of the conflict between imposing a professional standard of care in information disclosure and the need to protect patient autonomy. Both LPHP2005 and CEHP2013 seem to have left the authority to set the standard for informing patients to the professionals regardless of what patients want to know. Therefore, this shows that the current practice by Saudi Arabian medical law is in need of reform both to clarify the legal vacuum and to give more respect

¹⁷⁰ Ibid. chapter 2(D) p. 18.

¹⁷¹ Ibid. chapter 2(D)2 p. 18.

¹⁷² Obtaining consent with enough information is stated at CEHP2013 chapter 2 (C)1 p. 17 and reassuring patients with sufficient clear information is stated at CEHP2013 chapter 2 (D)2 p. 18.

¹⁷³ CEHP2013 chapter 2 (C)1 p. 17.

to patient autonomy by making it clear that a more patient centred standard should apply to the legal duty to disclose information. It will therefore be recommended that a clear statement imposing a prudent patient standard should be adopted, in line with the approach that has been taken in the first part of the *Montgomery* test in the UK.

C.3.1.2. Doctors' duty to ensure that the patient can understand the information

The duty of doctors to ensure that the patient can understand the information provided is also unclear in both LPHP2005 and CEHP2013. CEHP2013 has introduced the phrases that information must be provided 'in a language that the patient can understand'¹⁷⁴ and warn of 'the possible consequences of the patient's decisions'¹⁷⁵ which are not especially helpful. The first phrase seems to be more concerned about the description of the provided information itself and the language that is used. However, it does not require doctors to seek to ensure that the patient can understand the information. However, the second phrase provides a little more basis for a duty to seek to ensure that the patient can understand the provided information. Telling the patient about the consequences of his/her decision is an indication of doctors' duty to ensure that the patient can understand what he/she is going to consent to (or refuse).

Nonetheless, I would argue that the duty to seek to ensure that the patient can understand the information given is inadequately recognised in LPHP2005 and CEHP2013. So, in this area it can be learnt from the English law experience by placing a legal duty on doctors to take all proper steps to seek to ensure that the patient can understand the information given, as I will suggest in the Concluding Chapter. This is because it would be in compliance with Islamic *Sharia* general principles, as I have argued in Chapter two that Islamic *Sharia* requires those who provide advice to seek to ensure that the advice is clear, understandable and truthful.

C.3.1.3. Risk disclosure

Unlike LPHP2005, CEHP2013 seems to recognise that the doctors' duty to provide 'enough information' to the patient should include the 'potential complications and risks'.¹⁷⁶ However, I would argue that this phrase is not specific or clear in its meaning or scope. In particular, CEHP2013 does not provide further examples or explanations for what 'potential' risks may include – whether this is all potential risks, only significant ones and significant

¹⁷⁴ *Ibid.*

¹⁷⁵ *Ibid.*

¹⁷⁶ *Ibid.*

from whose perspective. Thus, I would argue such a lack of clarity should be addressed and the Saudi Arabian medical law can learn from the English law experience in doing so, by considering more respect for patient autonomy.

C.3.1.4. Doctors' duty to inform the patient about available alternative treatments

Unlike LPHP2005, CEHP2013 has advised doctors under the doctors' duty for 'achieving patient's interest and guarding his/her right'¹⁷⁷ to '...introduce them [the patients] to appropriate alternatives in diagnoses and treatment in a clear and honest way.'¹⁷⁸ This may suggest that CEHP2013 has recognised doctors' duty to inform patients about the available alternative treatments. Again, however, the CEHP2013 statement has not specified what kind of alternative treatments should be disclosed. Is it all available alternative treatments or just what may suit the patient's case? Should doctors inform the patient about the available alternative treatment voluntarily or just when the patient asks about the alternatives or refuses the offered treatment? From what has been said before, I would assume that because the professional standard is applicable, the doctors' failure to fulfil such a duty would be judged on that basis. This appears unsatisfactory in protecting the right of the patient to make a sufficiently informed decision so, I would argue that the current stance of the duty to inform the patient about available alternative treatments has to be clarified and this could be achieved by adopting the approach taken in English law.

C.3.1.5. Doctors' duty to answer patients' questions

The CEHP2013 under the matter of breaking bad news to the patient has recognised that: 'It is the right of the patient to know his/her health condition, illness, symptoms, and prognosis in general terms. *If the patient requires more details, he/she should be answered with that [information].* Informing the patient is the duty of the treating doctor...'¹⁷⁹ (Emphases added). This statement is made in relation to breaking bad news and further it might be suggested that providing further details at the patient's request is because the above statement has advised doctors to only inform the patient in general terms about his/her case. However, this does not deal with the general issue of needing to answer the patient's questions when seeking consent to treatment.

¹⁷⁷ *Ibid.* chapter 2(B) p. 17.

¹⁷⁸ *Ibid.* chapter 2(B) 3 at 17.

¹⁷⁹ *Ibid.* chapter 2(D) (Breaking Bad News) p.19.

Neither LPHP2005 nor CEHP2013 have dealt adequately with the issue of the doctors' duty to answer the patients' questions. Thus, this issue in its current stance generates a legal vacuum that need to be addressed. Again, it is suggested that this can be achieved by reforming the law in line with the duty in English law to answer patient's questions fully and truthfully, and this would be in line with Islamic *Sharia* to provide more respect for patient autonomy.

Having considered the standard of information disclosure and what ought to be disclosed to the patient, the final issues to be considered are those of deliberately withholding information from the patient: therapeutic privilege and where the patient does not wish to receive information.

C.3.2. Therapeutic privilege

LPHP2005 has recognised the notion of therapeutic privilege, as article 18 has allowed a doctor

*'...in cases of incurable or life threatening diseases to decide, at his own discretion, whether it is appropriate to inform the patient or his family of the nature of his disease, unless [the doctor was] prohibited to do so by the patient or if the patient designates a person to be exclusively informed.'*¹⁸⁰ (Emphasis added).

I would argue that, although article 18 has recognised the notion of therapeutic privilege so as to authorise the doctor to withhold information, it is limited that to cases of 'incurable or life threatening diseases',¹⁸¹ as CEHP2013 also states that in the event of breaking bad news to the patient, doctors should 'limit the information [to] that suits the patient's knowledge and understanding of his/her health condition without the minutiae that would increase his/her worry.'¹⁸²

Although article 18 has limited the use of the therapeutic exception to only some cases, it is still suffering from a lack of clarity. I would argue that, although article 18 has authorised doctors to estimate use of discretion in how to inform or not inform the patient, or his/her appointed deputy, LPHP2005 does not clearly state that withholding information should not take place simply because it is feared that the information may cause the patient to withhold consent, as that would deprive the patient of the opportunity to make his/her own decision in accordance with Islamic *Sharia*. Thus, leaving the estimation to the doctor would

¹⁸⁰ LPHP2005 article 18.

¹⁸¹ *Ibid.*

¹⁸² CEHP2013 chapter 2(D) 2 p. 19.

undermine the respect for patient autonomy, as the patient's wishes and priorities would be different from the doctor's. Thus, LPHP2005, by leaving the use of therapeutic exception without limitation, would deny the patient the right to make his/her free and own decision in accordance with Islamic *Sharia*. Thus, I would argue that, although English law has stated that the therapeutic exception should not be used to prevent the patient from making an informed decision or changing his/her decision, this issue has not been directly addressed in LPHP2005 and I will in the Concluding Chapter suggest that the application of therapeutic privilege should be similarly limited in Saudi Arabia.

C.3.3. Where the patient refuses information

Another interesting aspect of LPHP2005 in article 18 is to recognise patients' rights not to be informed and to transfer their rights to be informed to a person(s) that they have appointed.¹⁸³ However, I would argue that although article 18 seems to recognise the patient's right to refuse to be informed, that acknowledgement is subject only to cases of 'incurable or life threatening diseases'.¹⁸⁴ This may suggest that refusing information in such cases might be legally accepted in that case only, but otherwise not. Furthermore, I would argue that, according to CEHP2013, even where the patient is able to waive or transfer his/her right to information, the doctor still has a legal duty to tell the patient basic information and about the consequences of his decision.¹⁸⁵ Arguably, as such duty is not stated clearly in LPHP2005, I will suggest in the Concluding Chapter how that should be addressed by learning from English law experience.

In summary, based on what has been above discussed, the rules concerning the above issues remain vague among medical staff, patients, lawyers and even SMPs as, to-date, no clear structure exists for the amount of information or risks that should be disclosed to patients.¹⁸⁶ Having therefore examined the legal requirements for a valid consent and the current practice and deficiencies in Saudi Arabian medical law, in the following, the thesis will discuss the establishment of a doctor's civil liability for the failure to disclose information or risk to the patient based on Islamic *Sharia* and Saudi Arabian law.

¹⁸³ LPHP2005 article 18.

¹⁸⁴ *Ibid.*

¹⁸⁵ CEHP2013 chapter 2(B)3 p. 17 and chapter 2(D)2 p. 18.

¹⁸⁶ A Almoajel 'Hospitalized Patients Awareness of Their Rights in Saudi Governmental Hospital' (2012) 11(3) *Middle-East Journal of Scientific Research* 329-335 p. 333.

3.2.4. Consequences of failing to meet the standard of information disclosure and negligence

In the following, the thesis will briefly discuss the issue of establishing a doctor's civil liability for not informing the patient.

LPHP2005, in addition to recognising the patient's right to a civil remedy for an injury, considers the public interest which arises as an additional issue in the context of a civil action. That is, the doctor's action in breaching article 18 (inform the patient) should result in a fine (to be paid to the treasury),¹⁸⁷ whether there was an injury or not. Furthermore, SMPs can issue a warning or fine or suspend the doctor's licence for disciplinary liability.¹⁸⁸ Further, the patient should be compensated if the injury occurred as a result of the doctor's failure to inform the patient; SMPs will estimate the compensation amount.¹⁸⁹ However, it should be noted that, as the professional standard is currently applied in Saudi Arabian medical law, so the discussion will refer to it.

In what follows, the thesis will examine the doctors' failure to provide competent adult patients with information that they need to make a decision concerning proposed treatment, and how that failure would be considered by the law.

3.2.4.1. The duty of care

Generally, the duty of care as a legal concept has been recognised by Islamic *Sharia* for a long time, as the holy *Quran* recognises that a Muslim owns a duty to take care of his/her parents.¹⁹⁰ Further, Muslim scholars have agreed that learning medicine and treating patients is a collective obligation; thus it becomes a duty of one or a number of people to learn medicine and provide treatment to the community.¹⁹¹ Therefore, a doctor owes a duty to serve his/her community by preventing suffering or harm and promoting healthcare by providing treatment.¹⁹²

¹⁸⁷ LPHP2005 article 30. Stated that: 'For which no specific penalty is provided therein shall be punishable by a fine not exceeding twenty thousand [R]iyals.'

¹⁸⁸ Ibid. articles 31 and 32 sections 1,2 and 3.

¹⁸⁹ Ibid. article 27.

¹⁹⁰ The holy *Quran* translation states that 'So your Lord has decreed: Do not worship anyone but Him, and be good to your parents. If one or both of them grow old in your presence, do not say fie to them, nor reprove them, but say gentle words to them.' (CH17:23)

¹⁹¹ G Bowering *et al.* *The Princeton Encyclopedia of Islamic Political Thought* (PUP 2013) p. 103. See also T Glick, S Livesey and F Wallis *Medieval Science, Technology, and Medicine: An Encyclopedia*. (Routledge 2005) p. 195

¹⁹² CEHP2013 chapter 3(6) p. 22 stated that a doctor should '[s]trive hard through the use of his/her skills, knowledge and expertise to improve the standards and quality of health services available in the community, whether in the work place or in general.'

Nonetheless, there are different views regarding the basis of the doctor-patient legal relationship regarding whether it is contractual (*Ijareh*) or tortious.¹⁹³ Thus, if the patient has been treated by a private hospital or doctor in this case the legal relationship is a contractual as the patient and hospital/doctor has involved in a contract.¹⁹⁴ On the other hand, in public hospitals it can be said that the legal relationship is under tort law.¹⁹⁵ However, it can be argued that, regardless of the basis of the legal relationship, an agreement to treat establishes a duty of care; hence, it is not usually difficult to establish that a duty of care exists between a doctor and patient.¹⁹⁶ For example, LPHP2005, irrespective of the basis of the legal relationship, states that for an injury that has occurred as a result of medical malpractice the patient is entitled to be compensated.¹⁹⁷

A doctor is not always under an obligation to treat unless the case is an emergency and the doctor can provide treatment. In such emergency cases, doctors are under a legal duty to treat patients.¹⁹⁸ However, this duty is not just to provide appropriate treatment. It has been argued that another of the doctors' duties under Islamic *Sharia* is to provide patients with information.¹⁹⁹ Therefore, under a contractual relationship as well as under a wider concept of a duty of care, doctors should fulfil their obligations by providing the patient with information and performing the required and appropriate treatment or operation only after obtaining the patient's valid consent. It can be said that in this respect it is similar to English law.

3.2.4.2. Breach of the duty of care (*AlTaadi*)

As I have argued above, LPHP2005 in article 26 has only stated a general principle that doctors should conduct their duty in accordance with the common medical practice (the

¹⁹³ M Almaaitah *AlMasoawlih AlMadneeih wa AlInaeih fe AlAKhtaa AlTbeeih (The Civil and Criminal Liability for Medical Error)* (1st ed NAUSS 2004) p. 39 (Arabic).

¹⁹⁴ B AlShik *AlMasoeih AlQanoneih LAITabib. (Doctors' Legal Liabilities)* (1st ed Dar AlHamad 2002) p.166-168 (Arabic).

¹⁹⁵ M Hanna *AlNadrieh AlAlamh La alMasowlih alTabieh (the General Theory of a Medical Liability)* p. 38.

¹⁹⁶ M Almaaitah *AlMasoawlih AlMadneeih wa AlInaeih fe AlAKhtaa AlTbeeih (The Civil and Criminal Liability for Medical Error)* p.36-37.

¹⁹⁷ LPHP2005 article 27.

¹⁹⁸ *Ibid.* article 8 stated that: 'A healthcare professional who witnesses or becomes aware of a patient critically ill or injured shall provide all possible assistance or ensure that he receives required care.' article 16 LPHP2005 stated that: 'A healthcare professional may, in other than critical or emergency cases, decline from treating patients for professional or acceptable personal reasons.' CEHP2013 chapter 2(H) p. 21 stated that: 'The healthcare practitioner can - in a non-emergency situation, refrain from treating a patient for personal or professional reasons that would jeopardize the quality of care provided by the healthcare practitioner to the patient, on condition that this [refrain] does not harm the patient's health, and that there is another practitioner who is capable of treating the patient instead of him/her.'

¹⁹⁹ M AlBar and H Pasha, *Masoleet ATabeeb bein AlFqih wa AlCanoon (The Doctor's Liability Between Fiqh and Law)* p.30-31.

professional standard).²⁰⁰ However, LPHP2005 does not state whether SMPs should apply the professional standard to establish the doctor's civil liability for the failure to inform the patient.

Thus, I contacted²⁰¹ Counsellor Saeed Alghamdi, a current member of Jeddah SMP,²⁰² to find out what standard of care SMPs apply to examine doctors' civil liability in failing to disclose information or risks to patients as that is not clear in LPHP2005. Counsellor Alghamdi stated that: generally, to examine and establish doctors' liability in all medical cases including doctors' failure to disclose information or inform patients about risks involved in the treatment or operation, the SMP simply applies the professional standard of care as has been generally stated in article 26 in LPHP2005. This, I would argue, shows that LPHP2005 seems to some extent to consider the protection of patient autonomy, such as the emphasis in article 19 that no medical treatment should be provided unless a valid consent has been obtained.²⁰³ The LPHP2005 acknowledgement of the professional standard seems to marginalise that respect, as SMPs, by applying the professional standard, appear to leave the determination of doctors' civil liability to the professionals.

I would argue that this marginalisation by SMPs to consider the respect for patient autonomy seems to conflict with Islamic *Sharia* recognition of the principle of autonomy as the patient should be adequately informed, as I have discussed in Chapter two. Thus, SMPs seem to clearly deny respect for patient autonomy by applying the professional standard. I would argue the reason for that is because SMPs are just applying LPHP2005 as precedent law is not applicable in the country;²⁰⁴ thus, SMPs cannot go beyond what LPHP2005 has stated. Therefore, they cannot, for example, apply any other standard of care, unless LPHP2005 has stated what should be applied. In this regard, I would argue that replacing the current standard of care by the prudent patient standard of care must be conducted through legislation. Accordingly, by adopting the prudent patient standard of care that would give more protection to patient autonomy in accordance with Islamic *Sharia* can be achieved by learning from English law experience, as I will discuss later in this Chapter and the Concluding Chapter.

²⁰⁰ LPHP2005 article 26. The article has stated that: 'A healthcare professional governed by this Law [LPHP2005] shall exert due care in line with commonly established professional standards.'

²⁰¹ A personal communication on 25/12/2014 via e-mail.

²⁰² Counsellor Saeed Alghamdi has been appointed as a member of Jeddah SMP since 2009 as the Ministry of Health Counsellor representative.

²⁰³ See the discussion above.

²⁰⁴ See Chapter two for further discussion.

In the meantime, I would argue that the SMPs' application, consideration and interpretation of the professional standard is seemingly similar to that was held by Lord Diplock in *Sidaway* as I have discussed in Chapter three. His Lordship believed that the *Bolam* test's role was clear:

‘To decide what risks the existence of which a patient should be voluntarily warned and the terms in which such warning, if any, should be given, having regard to the effect that the warning may have, is as much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care to the individual patient, and expert medical evidence on this matter should be treated in just the same way.’²⁰⁵

However, a patient's claim should be submitted to a regional SMP. The basis for the patient's claim is based on the Messenger's PBUH general saying: ‘Were people to be given what they claim, men would claim fortunes and blood [lives] of people, but the onus of proof is on the claimant and the taking of the oath is incumbent upon the one who denies it [the allegation].’²⁰⁶ From this statement, it is clear that the burden of proof is always upon the claimant (the patient) because the defendant (the doctor) is presumed not liable according to the basic principle that ‘all people are innocent.’²⁰⁷ This approach of Islamic *Sharia* to put the burden of proof upon the patient is similar to English law. Thus, the patient must support his/her claim by bringing sufficient evidence which shows that the claim is valid as the holy *Quran* in translation states ‘...produce your proof if you are truthful.’²⁰⁸

LPHP2005 has instructed patients to support their claims with medical reports and the report that has been produced by the investigation committee in the hospital or clinic where the action has taken place.²⁰⁹ Those reports will be subjected to scrutiny by the SMP members and the parties' lawyers.²¹⁰ LPHP2005 has granted SMPs the right to appoint one or more external additional expert(s)²¹¹ to provide evidence in the courtroom and to provide a written medical opinion. SMPs may also do so at the patient's or the defendant's request. The expert evidence will be questioned in SMP hearings and sessions.²¹²

²⁰⁵ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 895.

²⁰⁶ Ibn Rajab Alhanbli *A Collection of Knowledge and Wisdom*, translated by M Fadel (Umm Alqura publisher 2002) p. 423.

²⁰⁷ *Ibid.* p. 425 compare to ‘you are assumed innocent until you are proved guilty’

²⁰⁸ The holy *Quran* in translation (CH2:111).

²⁰⁹ LPHP2005 article 35, section 3 in the executive regulation. (Arabic).

²¹⁰ *Ibid.*

²¹¹ *Ibid.* article 33 section 2.

²¹² *Ibid.* article 33, section 3 in the executive regulation.

The expert evidence will be examined against the conduct of the doctor in question on the professional standard. It is considered preferable to have two just, trusted, skilled and qualified experts in the same craft.²¹³ However, in some circumstances the view of a single just, trusted, skilled and qualified expert, is acceptable, for instance in cases where two experts in a particular field cannot be found.²¹⁴ To this extent, the view of Islamic *Sharia* and Saudi Arabian medical law seem to be similar to English law's view in *Maynard*.²¹⁵ SMPs have the authority to examine the content, credibility and reasonableness of the evidence, thus SMPs can accept or dismiss it,²¹⁶ but in the event of the dismissal, by law SMPs must give clear reasons for the rejection.²¹⁷

However, Saudi Arabian medical law appears to concentrate more on examining the credibility of the experts than the reasonableness of the evidence itself. As there is no written material on how the SMPs approach medical expert opinion in any medical case including information disclosure, I again asked Counsellor Alghamdi,²¹⁸ about that. He stated that the customary procedure of SMPs in considering the patient's claim (including the failure to disclose information) is that after receiving the claim, the case will be referred to one of the two expert doctors and a medical professor member of the SMP²¹⁹ to study the case and the evidence of the parties. If these members clearly consider that the doctor's action based on the case fact and the expert evidence was negligent, regardless of the defendant's expert views, the SMP will hand down its decision on that basis.²²⁰

On the other hand, Counsellor Alghamdi stated that if there is no clear evidence that the action was negligent or there is a doubt about the action or if the defendant's and the patient's experts' evidence is not credible, the SMP will then refer the case to external experts (appointed by SMP not the parties) in the same field for further study and consideration. Those external experts have to submit their opinions to the SMP and they will be summoned to discuss their opinions by the SMP members.²²¹ Hence, Counsellor Alghamdi indicated that if the majority of the SMP members are satisfied that the external medical experts' views

²¹³R Shaham *The Expert Witness in Islamic Courts: Medicine and Crafts in Service of Law*. p. 66-75.

²¹⁴Anwraullah *The Islamic Law of Evidence* (2nd ed Kitabkhavan 2006) p. 81.

²¹⁵See also *Defreitas v O'Brien* [1995] P.I.Q.R. P281. For further discussion, see Chapter three.

²¹⁶LPSC2013 article 138 stated that 'The experts' opinion is not binding on the court, which merely uses it as a guide'

²¹⁷LPHP2005 article 35 section 4 in the executive regulation. (Arabic).

²¹⁸A personal communication on 25/12/2014 via e-mail.

²¹⁹However, if the case involves a pharmacy error or if the defendant is a pharmacist, two additional members must join the SMP a professor from a pharmacy school and an expert pharmacist, so the case will be referred to one of them.

LPHP2005 article 33 section B. See the discussion above about the formation of SMPs.

²²⁰LPHP2005 article 35 section 4 in the executive regulation.

²²¹*ibid.* article 35 section 2 in the executive regulation.

are credible and in line with the professional standard then the SMP will base its judgment on that view, either to hold the doctor liable or not. However, if the majority of the SMP members are not satisfied, the case will be referred to other external experts (appointed by SMP not the parties). The SMP will follow the same procedure, and then at the end the SMP will decide by a majority which opinion is credible and which the SMP can ground its judgment on.²²²

I would argue that, because SMPs include medical professionals and lawyers, this may make the job of examining the credibility and reasonableness of the medical expert opinion easy and effective, compared with English law where judges are not expected to have medical knowledge, although this does still beg the question whether doctors are judging other doctors, even though they are doing so in a judicial role. Therefore, whether there is an element of judicial bias toward the defendant is questionable. I will propose some reforms to SMPs in the concluding remarks of this Chapter and the Concluding Chapter.

Additionally, I would argue that SMPs, by applying the professional standard to determine a doctor's liability including the failure to disclose adequate information, are undermining the respect for patient autonomy and empowering the professionals to determine the standard of care. Accordingly, I would argue that there are many questions that must be addressed in terms of applying the professional standard: how can it be stated that a patient had been sufficiently and properly informed? A deeper question exists here, however: who should decide what kinds of risks the doctor should disclose to the patient? Finally, who should set the standard of information disclosure – the professionals or the law – and why? It might be possible that, as both LPHP2005 and CEHP2013 are devoted and loyal to the professional standard, the answers to these questions I have asked are that it is the medical professionals not the law who can and should decide.

3.2.4.3. Damage/injury (*AlDarar*)

When establishing the doctor's civil liability, judges must be satisfied that physical or emotional damage or injury to patients was the result of the doctors' action.²²³ The damage/injury the patient suffered as a result of the doctor's action should be compensated.²²⁴ Accordingly, it can be said that where the doctor's failure to disclose

²²² A personal communication on 25/12/2014 via e-mail.

²²³ W ALZuhayli *Nadrait AlDaman 'Ahkam AlMsoelih AlMadneeih wa Aljenaeh fe AlFiqh Allslami'* (the theory of Islamic Civil and Criminal Liability) (9th ed AlFikr 2012) p. 29 (Arabic).

²²⁴ LPHP 2005 article 27.

information or risks to the patient resulted in damage/injury, the doctor should be held liable for that damage/injury.²²⁵ Further, the patient has a civil remedy for compensation that is based on the Islamic *Sharia* system of compensation,²²⁶ as the amount will be decided by SMPs.²²⁷

3.2.4.4. Causation (*Alifdha*)

Similar to the definition of causation under English law, Islamic *Sharia* and Saudi Arabian law define causation as a causal connection or link between the claimant's damage and the defendant's negligent action.²²⁸

In general, a defendant should not be held liable for his/her action unless there is a direct or indirect link to the damage/injury, so if there is no such link there is no liability. The examination and establishment of causation relies on several methods which include; expert evidence, the proof provided by the claimant or derived from the circumstances of the case *etc.* All of these will be considered and examined by judges to decide whether or not the defendant's action was the direct or indirect cause of the damage/injury.²²⁹

Thus, for judges to establish causation they will require evidence of the following:

1. There is no other cause for the damage/injury except the current defendant's direct or indirect behaviour.
2. There was no action by the claimant which increased the damage/injury or any agreement by him/her to the damage/injury.²³⁰

Based on Muslim scholars' understanding of Islamic *Sharia*, there are two types of causation: the first is the direct (*Mubshar*) cause.²³¹ This means that there is a direct connection between a person's action and the damage/injury that occurs.²³² The direct cause is considered by scholars and courts as the most clear contributor to the result. For a cause to be considered direct, there must be no other causes leading to damage/injury. Thus,

²²⁵M Albar and H Pasha *Masoleet ATabeeb bein AlFqh wa AlCanoon (The Doctor's Liability Between Fiqh and Law)* p. 75.

²²⁶P Kassim 'Medical Negligence in Islamic Law' p. 409-410.

²²⁷LPHP2005 articles 27 and 34 section 1.

²²⁸M AlMaaitah, *AlMasoolih AlMadneeh wa AlJnaeieh fe AlAKhtaa AlTbeeih (The Civil and Criminal Liability for Medical Error)* (1sted NAUSS 2004). P 61

²²⁹M Aldowsary *Daf AlMasoolih AlMadneeh wa Tabiqath AlQdaeiah (Abolishing the Civil Liability and its Judicial Application)* (1sted Eshbeila 2010) p 320

²³⁰Ibid. p 322.

²³¹The *Mejelle* Being an English Translation of *Majallah El-Ahakam-I-Adliya* and a Complete Code on Islamic Civil Law article 887.

²³²W AlZuhayli *Nadrait AlDaman 'Ahkam AlMsoelih AlMadneeh wa AlJnaeieh fe AlFqh AlIslami' (the Theory of Islamic Civil and Criminal Liability)* p. 31.

compensation must be paid as long as the direct cause is established. Moreover there is no requirement to establish that the defendant was intentionally intending the damage/injury; the only requirement is that the defendant's action was the direct result of the damage/injury.²³³ For example, say a person accidentally dropped a brick from his/her house's roof hitting a person on the street, causing him/her injury. Even although there was no intention by the defendant to drop the brick, his/her action was nonetheless the direct cause of the claimant's damage/injury and so the defendant should be held liable.

Second is the indirect (*Tasabbub*) cause, which means that the damage to the person was an indirect effect of the defendant's action.²³⁴ An indirect cause is considered as a 'second degree' cause that should be considered as the reason for the damage/injury, with the following conditions; namely, the defendant's action must be intentional, that action must be clearly the indirect cause of the damage/injury and there is no other cause that led to the damage/injury.²³⁵

So, scholars have agreed that the direct cause must be the main cause of any resulting harm, and the person whose action was the direct cause of the damage/injury should be liable to pay compensation. On the other hand, the indirect cause will be only considered as the main cause if it was the core cause of the result.²³⁶

For example, if false testimonies were given to the court that the defendant stole money and based on those untrue testimonies the judge ordered the appropriate penalty (in this case amputation) the testimonies were the indirect cause of the result as the witnesses did not cut off the defendant hand. The judge's order was the direct cause of the result, but because the result was the consequence of the false testimonies, those who provided them would be liable to pay compensation as they were the indirect cause of the harm. On the other hand, the judge should not be liable, because he merely applied and enforced the law based on the evidence presented to him. In this case, the indirect cause is significant in terms of compensation, while the direct cause is not.

²³³ M Aldowsary *Daf AlMasoolih AlMadneeh wa Tabiqath AlQdaeiah (Abolishing the Civil Liability and its Judicial Application)* p 324.

²³⁴ The Mejlle Being an English Translation of Majallah El-Ahakam-I-Adliya and a Complete Code on Islamic Civil Law. article 888.

²³⁵ M Aldowsary *Daf AlMasoolih AlMadneeh wa Tabiqath AlQdaeiah (Abolishing the Civil Liability and its Judicial Application)* p 325.

²³⁶ S Alghamdi *Masoleet Altabeeb Almahieih (Doctors' Professional Liabilities)* (3rd ed Alandalos, 2012) p 197- 198.

Based on that, Muslim scholars have established the general rules for direct and indirect causes as follows:

The direct cause is always the most relevant, except in the following situations:

1. The indirect cause will be considered the main cause if it is the primary reason for the damage/injury.²³⁷ For example, say a driver stopped his/her car for a red light and a driver from behind failed to stop in time and hit the first car, forcing it forward, hitting and injuring a pedestrian. The cause of the pedestrian's damage was not the direct hit by the front car; rather, it was the result of the second car's hitting the first car (indirect cause). Or the direct cause may be a direct result of the indirect cause.²³⁸ For example, if someone clearly coerced and forced another person to set fire to the claimant's house, while the damage to the house was the direct result of the arsonist's action, that direct cause would not have happened without the coercion of the first person (indirect cause).

2. The direct and indirect causes are equal, in this case both persons who caused the damage/injury are equal in liability to pay compensations.²³⁹ For example, if a person digs a hole in the ground without protecting passers-by by warning them, and another person pushes the claimant into it causing injury, both are liable, because both defendants share the blame.

In the case of healthcare delivery, unlike English law, Islamic *Sharia* and Saudi Arabian law apply an objective causation standard, which relies on deciding what a reasonable doctor would have disclosed to the patient.²⁴⁰ LPHP2005 has stated clearly that '[a]ny healthcare professional who commits malpractice causing harm to a patient shall be liable for indemnification'.²⁴¹ Based on this article it can be understood that there must be a causal connection between the doctor's treatment or intervention and the damage/injury that occurred.²⁴²

In applying an objective causation standard, LPHP2005 focuses on the occurrence of the damage/injury, and so as long as there is a (physical or non-economic) damage/injury as a

²³⁷ M Aldowsary *Daf AlMasoolih AlMadneeh wa Tabiqath AlQdaeiah (Abolishing the Civil Liability and its Judicial Application)* p 327-328.

²³⁸ *Ibid.*

²³⁹ *Ibid.* p 329.

²⁴⁰ M AlMaaitah, *AlMasoolih AlMadneeh wa AlInaeih fe AlAKhtaa AlTbeeih (The Civil and Criminal Liability for Medical Error)* p 61.

²⁴¹ LPHP2005 article 27.

²⁴² P Kassim 'Medical Negligence in Islamic Law' p. 406.

result of a breach of the duty of care, the doctor should be held liable for that damage/injury. In fact, LPHP2005 does not deal with the issue of information disclosure differentially or separately; it considers it in the same way as any other medical negligence allegation. Thus, if the patient suffers damage/injury as result of the doctor's failure to provide him/her with the required information, or if the information that was disclosed to the patient was not true or was misleading and the patient suffers damage/injury as result of that, SMPs will examine whether there is a causal link (direct or indirect) between the doctors' failure to inform the patient and the damage/injury.²⁴³

In order for SMPs to investigate and establish doctors' civil liability, they rely on medical experts' evidence, because doctors' failure to inform the patients about risks or the required information needs to be examined against what would or would not a reasonable doctor in the same circumstances disclose (based on the professional standard of care).²⁴⁴

Thus, for SMPs to establish causation, they apply an objective standard. Hence, in all the cases where the doctors failed to provide the patient with the required information or provide him/her with wrong or misleading information, SMP members apply Muslim scholars' interpretations. It should be remembered that Muslim scholars consider all causes (not only the most effective causes) that lead to a damage/injury, so whether the cause is direct or indirect and whether they have occurred separately or cooperated with each other, they will be examined in order to evaluate each one's relationship to the damage/injury.²⁴⁵ This method is also applied to doctors' actions in allegedly failing to inform the patient.²⁴⁶

In order to identify and declare who is responsible for the patients' damage/injury and apportion responsibility for it, Muslim scholars have instructed judges to examine each action or inaction that was involved in the claimant's damage/injury and, based on each person's participation in causing the damage/injury, both the responsibility and amount of compensation will be set and identified.²⁴⁷

So, SMPs based on the medical experts' opinion (and evidence provided by the claimant) and by applying the professional standard of care examine and consider all causes that

²⁴³ LPHP2005 article 27.

²⁴⁴ *Ibid.* article 26.

²⁴⁵ M Alqhatani *Alndam AISaudi LeMzawlat Mehant Altab AlBasheri wa Tab AlAsnan (The Saudi Arabian law of Practicing Medicine and Dentistry Professions)* (1sted 2002 KSUP) p. 104-105.

²⁴⁶ See for example, the Administrative Court of Appeal case no (890/1/A) in 2003.

²⁴⁷ M Alqhatani *Alndam AISaudi LeMzawlat Mehant Altab AlBasheri wa Tab AlAsnan (The Saudi Arabian law of Practicing Medicine and Dentistry Professions)* p. 104.

resulted in the damage/injury, then identify and link each cause to the result. Thus each person involved in causing the patient's damage/injury should be held liable based on the contribution of his/her action to the result and the amount of compensation will be set accordingly.

Bear in mind that the establishment of causation will be examined against whether there is an external factor which cut the causal link or not, such as the patient's refusal to follow the doctor's instructions which then leads to the damage/injury.²⁴⁸ Consequently, the doctor should not be held liable because there is no causal link between his/her action and the damage/injury.²⁴⁹

For example, a patient underwent an eye operation (laser) to correct his vision in both eyes. The ophthalmologist informed the patient about the risks and consequence that could possibly happen in such an operation and the ophthalmologist correctly performed and operated on the patient's eyes. After few months the patient started to suffer some pain in both eyes and his vision deteriorated. The patient brought a claim arguing that the deterioration of his vision was caused by the negligent performance of the operation.²⁵⁰

The SMP in Ash-Sharqiyyah examined the cause of the deterioration of the patient's eyes and, based on medical experts' view, which stated that:

‘..the patient eyes have devolved a rare condition (Keratoconus) which was caused by the nature of the patient's eyes not by the operation..., it is very rare in practice for such an operation to lead to the similar outcome, thus the damage to the patient's eyes was directly caused by the nature of the patient's eyes and not by the operation.’²⁵¹

In terms of information and risk disclosure, the medical experts' view was that: ‘It is an acceptable and a usual practice for the ophthalmologist in the same situation to not inform the patient about the rare risk of Keratoconus...’²⁵² Therefore, medical experts' came to the conclusion that

‘...there was no direct or indirect causal link between the operation and the damage to the patient's eyes, the damage was a direct result of the nature of the patient's eyes. Further, the ophthalmologist's action to not inform his

²⁴⁸ M Mansor *ALMosoleeih Altabieh (Medical Responsibility)* (1st ed Monshat AlMaareef) p169

²⁴⁹ *Ibid.*

²⁵⁰ The Administrative Court of Appeal case no (890/1/A) in 2003. p1-3.

²⁵¹ *Ibid.* p10.

²⁵² *Ibid.* p11.

patient about the rare risk involved is in accordance with acceptable medical practice in his field.²⁵³

The SMP in Ash-Sharqiyyah adopted the medical experts' conclusion and dismissed the case. The decision was upheld by the Administrative Court of Appeal.

Here the SMP merely relied on the medical experts' views to examine the ophthalmologist, based on the professional standard of care. As there was no causal link between the ophthalmologist's action and the damage, the case was dismissed.

In another case, a patient was admitted to the emergency department in a private hospital, complaining about a pain in his lower right abdomen. The doctor who diagnosed him, believed that the patient's pain was caused by inflammation of the appendix and she strongly advised him to have his appendix removed immediately without any delay. The patient consented and was transferred to the operating theatre where the operation was conducted.²⁵⁴

A few days after his discharge from the hospital, the patient was complaining of severe pain in the area of the operation, and swelling. He was taken to another hospital where he was informed that his case had not required an instant removal of the appendix, because the condition was not severe and he could be treated without surgery. In addition, the operation to remove the appendix had not been performed correctly. Consequently, the patient needed another operation to relieve him from the pain and correct the previous operation.²⁵⁵

The patient brought a claim to the SMP in Riyadh, arguing that he was given misleading information about his condition and further that the doctor who operated was negligent, because he was not a specialist in this kind of operation.

Medical experts' opinion was sought, which confirmed that first, in terms of informing the patient '...the doctor was not acting in accordance with an acceptable practice by misleading the patient about the urgency of his case which was not urgent.'²⁵⁶ Second the doctor who operated was not a specialist so he was ignorant about the operation. The medical experts then concluded that the patient's damage was a result of both doctors' actions.²⁵⁷

²⁵³ Ibid.

²⁵⁴ The Administrative Court of Appeal case no (192/8/A) in 2010.p1-5.

²⁵⁵ Ibid.

²⁵⁶ Ibid. p 7.

²⁵⁷ Ibid. p 8.

The SMP in Riyadh, based on the medical experts' view, concluded that both doctors were liable for the patient's damage. The SMP in Riyadh established causation, and consequent liability, by dividing their responsibilities as follows:

‘.... based on the medical expert’ opinion..... doctor A shared a third of the causation to the damage because, she gave misleading information to the patient and urged him to have the operation which was not urgently required, so the patient missed other chances for example, to be treated by other ways or to have another opinion regarding his case or to have the operation in another day etc. so, the patient was deprived from taken a proper decision. On the other hand, the surgeon shared two-thirds of the causation to the damage, because firstly he was not a specialist to perform the operation and secondly he operated erroneously. Further, the surgeon is liable for breaching the prevision of articles 27 and 28 from LPHP2005 by exceeding his specialty..... Therefore, doctor A has to pay third of the compensation and the surgeon has to pay two-thirds of the compensation beside that he has to pay fine to the treasury for his breach...’²⁵⁸

The decision was upheld by the Administrative Court of Appeal.

This case shows how link of causation can be divided and how SMPs identified each parson relation to the cause. In doing that, SMPs relied on medical experts' view which applied the professional standard of care to establish the doctors' liability.

So, whether the cause is direct or indirect a doctor should be liable if his/her action caused the damage/injury. Thus, in the following the thesis will present the examination of direct and indirect causation applying to information disclosure and the SMPs' role in establishing causation. It should be remembered that the objective standard of causation is applied based on the professional standard of care.

1. If doctors' failure to inform the patient about the risks was the direct cause of the patient's damage/injury they should be liable;²⁵⁹ for example, when the doctor directly provides the patient with misleading information or withholds significant risks.

2. If doctors' failure to inform the patient was the indirect cause of the patient's damage/injury, the doctor should be liable;²⁶⁰ for example, when the doctor provides the wrong information to a nurse, who then passes it on to the patient. Here, although the nurse was the one who directly informed the patient, the damage/injury was linked to the action of

²⁵⁸ Ibid. p10-11.

²⁵⁹ M Alqhatani *Alndam AISaudi LeMzawlat Mehant Altab AlBasheri wa Tab AlAsnan (The Saudi Arabian law of Practicing Medicine and Dentistry Professions)* p. 104.

²⁶⁰ Ibid.

the doctor who provided the false information in the first place. Thus it is the doctor, not the nurse, who should be held liable.

3. If the direct and indirect cause of the patient's damage/injury are equal, those who caused the damage/injury should all be liable.²⁶¹ For example, when the doctor and nurse knew that they were withholding significant risks from the patient (not under the application of therapeutic privilege), both should be liable: the doctor, for his/her indirect causation (as he/she did not directly inform the patient) to not disclose significant risks and the nurse for his/her indirect causation (as he/she provided inadequate information).

To sum up, to establish causation in all medical cases, the objective causation standard will be applied to judge doctors' behaviour based on what a reasonable doctor would or would not do in the same circumstances. Obviously, that is because LPHP2005 adopts the professional standard of care.²⁶²

Therefore, replacing the professional standard of care in relation to information disclosure with the prudent patient standard in LPHP2005 would change the approach that SMPs apply to establish causation in cases where a doctor fails adequately to inform the patient. So, the test of causation would be an objective test relying on what a reasonable patient would have decided if he/she had been given the information. Thus the question SMPs should ask is whether: If the patient had been advised of the risk of the medical treatment, would he/she have consented (or not) to treatment or chosen other available options or sought other views or advice and that would be judged from a reasonable patient perspective.

So, applying the prudent patient standard of care would only require the patient to demonstrate that the disclosure of risk would have meant that they would not have consented to the medical treatment or operation at that time. As both Islamic *Sharia* and Saudi Arabian medical ethics recognise respect for autonomy,²⁶³ the move to the prudent patient standard would be consistent with their underpinning principles and would provide more protection to patient autonomy. This would also change the way(s) in which causation is established and liability apportioned.

²⁶¹ *Ibid.*

²⁶² LPHP article 26. The article stated that: 'A healthcare professional governed by this Law [LPHP2005] shall exert due care in line with commonly established professional standards.'

²⁶³ See Chapter two.

3.3. Summary

Although both LPHP2005 and CEHP2013 have recognised patients' right to be provided with 'enough information' I would argue that neither of these documents have mentioned or considered a number of key issues. I have argued that there is room for the notion of respecting the patient's autonomy in Saudi Arabian medical law. Islamic *Sharia* supports this, as long as that respect is not given to acts that are against its tradition. However, Saudi Arabian medical law does not seem to sufficiently protect patients' autonomy, as LPHP2005 has not specifically addressed the issue of the appropriate standard of information disclosure. In the absence of such a specific provision, the general standard of care in article 26 appears to have been adopted. In article 26 LPHP2005 has recognised that doctors should generally perform and conduct their duties to patients in accordance with the professional standard. This approach has not been disputed in CEHP2013 and it has been adopted in practice by SMPs.

Therefore, I would argue that the current practice by Saudi Arabian medical law and its devotion to the professional standard of care has evidently failed to meet the thesis's proposed standard of care, since it relies on a professional standard and does not address important issues that affect patient decision-making in a way that sufficiently protects their autonomy. Thus, I would argue that Saudi Arabian medical law needs to be reformed and that reformation should start by giving more respect for patients' autonomy in accordance with Islamic *Sharia* as I have discussed in Chapter two.²⁶⁴ Such recognition, I would argue, would support a departure from applying the professional standard of care to information disclosure, as this undermines the notion of respecting patients' autonomy. So, can the professional standard of care be replaced by a standard that gives more protection to patients' autonomy?

4. The new proposal to depart from the professional standard of care

4.1. The proposal

I have argued in Chapter two that Islamic *Sharia* medical ethics seem to recognise the notion of the respect for patients' autonomy in accordance with its tradition. Further to that, I have above discussed that LPHP2005 holds the strong view that a treatment or operation should not be performed until a consent has been granted.²⁶⁵ In fact, LPHP2005 does not stop there;

²⁶⁴ See Chapter two for further discussion.

²⁶⁵ LPHP2005 article 19. See also the discussion above regarding the development of consent law in Saudi Arabia.

it also, as I have above stated, considers the violation of article 19 in LPHP2005 to not obtain consent as an offence of breaching the law; thus, doctors should be penalised for that breach.²⁶⁶ In addition, the patient is entitled to a civil remedy for the damage/injury that occurred.²⁶⁷ Further to that, LPHP2005 has stated that the patient's choices and wishes should be respected as long as they are in harmony with Islamic *Sharia* and Saudi Arabian law,²⁶⁸ failure to do so would hold doctors liable for breaching LPHP2005.²⁶⁹ Additionally, doctors' who fail to comply with article 18 (to inform the patient) should be fined,²⁷⁰ and the patient who suffered damage/injury should be compensated.²⁷¹

I would argue that, based on the above articles, LPHP 2005 appears to some extent to protect and consider the respect for patient autonomy, although, article 26 in LPHP2005, as I have argued above, seems to acknowledge that doctors should conduct their duties based on the professional standard. Thus, there is a potential conflict between the need to protect health (paternalism) and the need to respect autonomy, and, so far LPHP2005 may be read, and has been interpreted, as placing greater emphasis on the former. That, I would argue can be understood clearly from the application of the professional standard by SMPs, as they apply the professional standard for all medical cases and the professionals have the power to determine the standard of care, and consequently doctors' civil liability. Therefore, it can be said that both the principle of respect for autonomy and the principle of respecting the judgment of doctors and their role in protecting the health interests of the patient are contained in LPHP2005, but greater priority seems to have been given to the latter.

In fact, I would argue that there has been insufficient consideration of the issue of respect for autonomy in LPHP2005 and that it would be compatible with Islamic *Sharia* to address this by introducing reforms to give greater protection in respect of the patient's right to information. However, it should be remembered that, if there is no clear statement by the main sources of Islamic *Sharia* on a specific matter, the door is opened for debate to arrive at a view on which there is consensus. This therefore includes information disclosure to patients. Thus, like the professional standard of care, the prudent patient standard of care seems to have a place and support in Islamic *Sharia*. I have argued in Chapter two that

²⁶⁶ Ibid article 28 section 7 and articles 31 and 32 sections 1,2 and 3. See also the discussion above regarding the development of consent law in Saudi Arabia.

²⁶⁷ LPHP2005 article 27. See also the discussion above regarding the development of consent law in Saudi Arabia.

²⁶⁸ Ibid. article 5 section 1 executive regulation.

²⁶⁹ Ibid. article 30.

²⁷⁰ Ibid.

²⁷¹ Ibid article 27.

Islamic *Sharia* to some extent has recognised the principle of respect for autonomy, consequently patients should be informed and their choices and wishes should be respected as long as they in compliance with Islamic *Sharia*. Thus, if the question is ‘Which standards of care (the professional or prudent patient) seem to be more protective for patient autonomy based on to the Islamic *Sharia*’s view?’, I would argue that the prudent patient standard seems to be the standard that protects patient autonomy and can be imposed by the law, as the comparative English law recent experience tells us.

I would argue that there has been comparatively little scholarly debate over the discussion of the prudent patient standard in Saudi Arabia so far, compared with that in English law. In fact, I would argue that this thesis would provide a basis for debating the issue to replace the current Saudi Arabian medical law standard of care by one that considers patient autonomy in accordance with Islamic *Sharia*. Thus, as I have argued in Chapter two that Islamic *Sharia* and Saudi Arabian medical ethics have recognised an ethical duty on the patient to be provided with information, nonetheless they have not set a standard of what should be disclosed. This view by Islamic *Sharia* and Saudi Arabian medical ethics seem to be considered by LPHP2005 and CEHP2013, as both, as I have discussed above, have recognised that doctors have a legal duty to inform patients. Nonetheless, LPHP2005 seems to acknowledge the professional standard; thus, doctors’ failure to fulfil such duty should be examined based on that basis.

In fact, Islamic *Sharia* seems to have no objection to considering and accepting a standard of care that gives more protection to patient autonomy and to form that in a legal duty as long as that does not conflict with its traditions. Additionally, as I have argued above that LPHP2005 seems to hold some recognition of the respect for patient autonomy, but that is not demonstrated clearly, thus the professional standard seems to be more appreciated even by SMPs. However, I would argue that LPHP2005 should be formulated based on Islamic *Sharia* as any law in the country should be passed accordingly,²⁷² but it seems that LPHP2005 gives more protection to the professionals and profession of medicine. I would assume that recognition by LPHP2005 may only reflect the policy of the government to give more protection to the medical professional rather than to the patients. As Islamic *Sharia* has no reference to a specific standard of care, in such cases the government can decide what standard should be adopted.

²⁷²BLG1992 article 7.

The important point is that there are no philosophical or theoretical problems in adopting the proposed new standard. With very limited exceptions, arguably the proposed standard sits comfortably with the traditions of Saudi Arabian and Islamic *Sharia* laws. From a practical point of view, translation of the new standard into law is more complex since Saudi Arabian law is not judge made, but rather relies on the legislature. The Saudi Arabian legal system is based on Islamic and written law so to change the standard of care may take some time, as the proposal for change either has to be proposed by the government or by the *Shura* Council.²⁷³

Nonetheless, the prudent patient standard of care has been under consideration by researches, a major conference²⁷⁴ and writers recognising the desire to move towards a standard of care that is more protective of patients' autonomy and rights. This would suggest that there is already movement to accept the prudent patient standard of care and this may convince the legislative bodies in Saudi Arabia to replace the current professional standard of care.

This movement can be seen in the work of scholar Dr. Qais Almubarak who is a senior Saudi Arabian scholar and member in the GPSRI, and one of his interests is medical law.²⁷⁵ He has studied the issue of medical law from a comparative legal perspective and Islamic *Sharia*. He has published two books on medical law based on Islamic *Sharia* - one of them is *AlTadawi wa AlMasoelih AlTabieh fa Alshria Alislamia (Treatment and Medical Liability based on Islamic Sharia)* (cited in this thesis) the other is *AlAaqad AlTabbi (Medical Contract)*.²⁷⁶ In the latter, scholar Almubarak discussed the issue of doctors' legal duty to inform the patient (*AlTabsser*) he stated that this duty is established ethically based on respect for the person's bodily integrity and right not to have his/her body violated. Thus not to inform the patient is disregarding of these rights.²⁷⁷ The duty to inform the patient is legally based on the doctor and patient contractual relationship (in private healthcare) or on tort law (in public healthcare).²⁷⁸ Thus providing patients with information is a basic ethical and legal right that must be protected and respected based on Islamic *Sharia* traditions.

Then scholar Almubarak has argued that doctors have a legal duty to provide the patient with sufficient and understandable information which gives the patient a clear picture about

²⁷³ See Chapter two for further discussion.

²⁷⁴ See the thesis Introduction.

²⁷⁵ Scholar Qais Almubarak website <http://www.qaisalmubarak.com/qais/ar/About> (accessed 14/03/2014) (Arabic)

²⁷⁶ Q Almubarak *AlAaqad AlTabbi (Medical Contract)* (3rded Dar Alemman 2013) (Arabic).

²⁷⁷ *Ibid.* p. 248

²⁷⁸ *Ibid* p 248, see also LPHP article 18 and 26.

his/her condition so as to enable the patient to make a free decision.²⁷⁹ Scholar Almubarak then believes that this duty includes informing the patient about the risk(s) involved in the treatment and inform him/her about any available alternative treatment.²⁸⁰ He then extended that duty to the legal requirement for doctors to take all steps to ensure that the patient can understand the provided information. Thus, for doctors to fulfil that duty they should provide information in a simple and understandable way using language which allows the patient to understand and utilise it. Further, doctors should be sure to use a good manner and be sympathetic in informing the patient, taking into account the seriousness of the patient's condition and his/her psychological state and disclosing the information gradually to the patient so as not to cause him/her stress or anxiety. Thus, it is possible under some circumstances to withhold information that would cause deterioration in the patient's health, but that should not deprive the patient from making a free decision.²⁸¹

Scholar Almubarak then asked how that duty can be performed? In other words, what is the standard of care to inform competent adult patients? He has stated that 'doctors must disclose relevant and material information regarding treatment and its risks that a reasonable person in the patient's position would want to know in order for him/her to decide to accept or refuse medical treatment.'²⁸² This view by Scholar Almubarak essentially endorses the prudent patient standard which has been argued for here. I would agree with his justifications that this standard is accommodated by Islamic *Sharia* because:

1. Islamic *Sharia* recognises that competent adult patients have the right to consent to or refuse medical treatment and no one can touch them without their valid consent.²⁸³ Thus for that right to be protected and for consent to be legally valid, patients must be informed about their health conditions, any material risks, alternative available treatment and the consequence of the treatment as that would allow the patient to make a free decision.²⁸⁴
2. This standard can be fulfilled by doctors and the law can ensure that the patient's right to be informed is protected. Thus, this standard on the one hand would not require doctors to disclose every single piece of information that a particular patient wants (subjective patient standard); instead it is based on what a reasonable patient wants or needs to know which

²⁷⁹ Q Almubarak *AlAaqad AlTabbi (Medical Contract)* p. 255

²⁸⁰ *Ibid* p. 253-255

²⁸¹ *Ibid* p. 250-251

²⁸² *Ibid* p. 255

²⁸³ See the discussion above about consent.

²⁸⁴ Q Almubarak *AlAaqad AlTabbi (Medical Contract)* p. 249-250

would not put a huge burden on the doctor to spend too much time informing the patient about all available information and risks. On the other hand, this standard can be applied by the law which then can examine doctors' failure to provide the patient with the required information based on what a reasonable patient wants to know.²⁸⁵ Thus this standard would seek a balance between patients' right to be informed and doctors' duty to provide information and would represent the justice balance that Islamic *Sharia* acknowledges. The holy *Quran* states: 'Verily God has enjoined justice, the doing of good, and the giving of gifts to your relatives; and forbidden indecency, impropriety and oppression. He warns you so that you may remember.'²⁸⁶

It should be remembered that, as I have argued in Chapter three, the standard in *Montgomery* is beyond the prudent patient standard, although it seems to suffer from some uncertainties. For example, although *Montgomery* has recognised doctors' legal duty to inform patients about the available alternative treatment, the Supreme Court does not attempt to identify or set a guidance regarding when alternative treatments should be disclosed, so that would be a subject for lower courts to consider.²⁸⁷ Further, although the issue of understanding was considered by the Supreme Court as generally doctors should take all reasonable steps to seek to ensure that the information given can be understood by the patient, the Supreme Court has not stated how this duty should be conducted.²⁸⁸ This as well will be subject to the interpretation of the lower courts. Therefore, the thesis will be aware of these concerns when suggesting that Saudi Arabian medical law can learn a lesson from English law to adopt the prudent patient standard.

However, English law has taken more than 30 years to replace the professional standard by a standard that is beyond the prudent patient standard, but has the element of the prudent patient standard. This replacement has not occurred instantly, as during these 30 years considerable and rich legal and academic literature to critically evaluate, discuss and develop the standard, has been produced. Additionally, English courts took considerable time to interpret the standard since it was set in *Sidaway*. Thus, the recent decision arrived at in *Montgomery* has been reached through a gradual and progressive 30-year journey, as I have discussed in Chapter three. However, as the decision in *Montgomery* has just arrived, thus it

²⁸⁵ Ibid p 249-250

²⁸⁶ The holy *Quran* (CH16:90).

²⁸⁷ C McGrath 'Trust me, I'm a Patient': Disclosure Standards and the Patient's Right to Decide' p. 214 and R Heywood 'R.I.P. Sidaway: Patient-Oriented Disclosure —A Standard Worth Waiting for?' p. 464.

²⁸⁸ R Heywood 'R.I.P. Sidaway: Patient-Oriented Disclosure —A Standard Worth Waiting for?' p. 465.

should be carefully considered and interpreted. Therefore, I would argue that Saudi Arabian medical law, which has been using the professional standard for many years, should first move to the prudent patient standard, as that would be the starting point to make a considerable change in LPHP2005. Then the standard should be subjected to critical discussion and observation by legal and academic literature, and doctors and patients' views must be considered.

Further, Saudi Arabian medical law appears to place more emphasis on the protection of the profession of medicine and doctors; thus the adoption of the prudent patient standard of care would reduce doctors' power to determine the standard of care and would also provide more protection to patient autonomy.

Therefore, I would argue that the prudent patient standard would be for Saudi Arabian medical law the best thing that the law can do (as Lord Scarman in *Sidaway* said). That is because Islamic *Sharia* has recognised the respect for patient autonomy within its context and the prudent patient standard can be imposed by the law, as English law experience shows.

Additionally, I would argue that the acceptance of the prudent patient standard by Saudi Arabian medical law as a starting point for further development can be supported by the current attitudes among doctors and patients in the country. In their book *Contemporary Bioethics Islamic Perspective*, AlBar and Pasha have argued that patients' views in some Islamic countries regarding the notion of autonomy have been changing as patients become more attracted to the concept of respect for individual autonomy as a result of greater education and knowing about their rights.²⁸⁹ This appears to be supported by journal articles in the last four years although there are a few older sources that also comment on this phenomenon.²⁹⁰ As it seems that some patients in some of Saudi Arabian hospitals have become aware of the need for respect of their autonomy and their decision to be respected,²⁹¹ thus I would argue that Saudi Arabian medical law should clearly consider the protection of

²⁸⁹ M AlBar and H Pasha *Contemporary Bioethics Islamic Perspective* p. 110-111.

²⁹⁰ There are older references to the issue for examples, A Mobeireek *et al.* 'Information Disclosure and Decision-making: The Middle East versus the Far East and the West' (2008) 34 *J Med Ethics* 225-229 K Saeed 'How Physician Executives and Clinicians Perceive Ethical Issues in Saudi Arabian Hospitals'.

²⁹¹ M Abolfotouh and A Adlan 'Quality of Informed Consent for Invasive Procedures in Central Saudi Arabia' p. 273.

the notion of the respect for patient autonomy as that would give patients more confidence that they were being respected.²⁹²

A very recent study published in 2014 was interesting even in its title: ‘Patients’ perceived purpose of clinical informed consent: Mill’s individual autonomy model is preferred’.²⁹³ From the first instant, the study’s title shows its conclusion, and its reference to Mill is significant in terms of the arguments made in Chapter one of this thesis and in terms of the thesis’s arguments that it is appropriate to consider the development of English law based on Western ethics when proposing legal reform for Saudi Arabia. The study’s researchers observed that: ‘According to [a] Millian account of autonomy, it is important to promote patient’s self-reflection and enable patients to decide for themselves.’²⁹⁴ The study held that the Millian concept of autonomy considers it as personal control,²⁹⁵ thus:

‘Patients cannot simply trust the clinician to take good care of them; they cannot freely decide to live in an obedient way, ignore information, or let others decide. They [patients] should control their course of treatment according to their point of view, a complex and dynamic outcome of not only judgments but also emotions, beliefs, desires, and habits.’²⁹⁶

The authors, based on their understanding of Mill’s concept of autonomy in regard to informed consent, designed a study which included a sample of 488 adult patients. The main aim of the study

‘was to explore how the purpose of the informed consent process is conceptualized [*sic*] by patients who are planning to undergo or who had recently undergone a written informed consent-requiring procedure in a tertiary care center [*sic*] in Saudi Arabia.’²⁹⁷

The findings of the study are very interesting, as it found that the choice of the statement that the purpose of informed consent was to

‘help patient decide’ was the best overall result, as it ‘was ranked 1–3 (out of 10) by 65% of respondents, and was ranked significantly different from the competing statements, indicating that the dominant patients’ view of informed consent’s purpose is enabling patients’ self decision-making.’²⁹⁸

²⁹² M Khedhiri, A Adlan and M Abolfotouh ‘Informed Consent in Clinical Care: Models of Patients’ Satisfaction and Attitude Based on General Trust and Risks Disclosure’ p. 1276

²⁹³ M Hammami *et al.* ‘Patients’ Perceived Purpose of Clinical Informed Consent: Mill’s Individual Autonomy Model is Preferred’ (2014) 15 (2) *BMC Medical Ethics* 1-12

²⁹⁴ *Ibid.* p. 3

²⁹⁵ *Ibid.*

²⁹⁶ *Ibid.*

²⁹⁷ *Ibid.*

²⁹⁸ *Ibid.* p. 9

This finding by the study is an example that shows the awareness among medical staff of the notion of informed consent as well as its importance to respect for patients' autonomy. In addition, the outcome of the study would suggest that many of the patients involved believed that informed consent would be a means to enable them to make their decisions.²⁹⁹ The study concluded that the notion of informed consent is vital for patients. Thus, to provide patients with information would enable them to be self-determining, allowing the provision (or withholding) of an informed consent.³⁰⁰

4.2. Concluding remarks

Based on what has been discussed, it seems that the thesis proposal to recommend Saudi Arabian medical law to depart from the professional standard of care and adopt the prudent patient standard of care is a defensible proposal. I would argue that it seems clear that the acceptance then the adoption of the prudent patient standard of care would not be a controversial issue in Saudi Arabia.

First, because, as I have argued in Chapter two, Islamic *Sharia* has recognised the principle of respect for autonomy based on its principles, and an adoption by Saudi Arabian medical law of the prudent patient standard would provide more protection to patient autonomy.

Second, the discussion in Chapters two, three and four has shown that the prudent patient standard can be regarded as consistent with Islamic *Sharia* principles, and it is not necessary to take a professional practice approach only.

Third, LPHP2005 seems to acknowledge the principle of respect for patient autonomy, as that can be understood from the emphasis on obtaining patients' consent and respecting their choices in accordance with Islamic *Sharia* and Saudi Arabian law.³⁰¹ LPHP2005 has also recognised a legal duty on doctors to inform the patient and failure to fulfil that duty would hold doctors negligent.³⁰² This shows that LPHP2005 contains potential acknowledgment of the respect for patients' autonomy, but the significant matter with LPHP2005 is its affirmation of the professional standard of care, which seems clearly to exhaust and undermine the respect for patient autonomy.³⁰³ A clear example is the SMPs' acknowledgment and reliance on the professional standard to determine the standard, and

²⁹⁹ *Ibid.* p. 8-9

³⁰⁰ *Ibid.* p. 11

³⁰¹ LPHP2005 article 5 and 19.

³⁰² *Ibid.* articles 18 and 30.

³⁰³ *Ibid.* article 26.

consequently doctors' civil liability. Therefore, I would argue that, as LPHP2005 potentially has a place for respecting patients' autonomy in accordance with Islamic *Sharia*, LPHP2005 can therefore adopt the prudent standard of care, as that would provide protection to patients' autonomy and that can be imposed by the law, as English law experience has shown. Thus, the adoption of the prudent patient standard by LPHP2005 is possible and practical.

Fourth, based on the surveys, studies and the current view by scholar Almubarak above it is evidently that an increasing number of patients and medical professionals are already aware and accepting the notion of informed consent and support its use as a means of enabling patients to make medical decisions.³⁰⁴ Thus, it can be argued that there is some support and acceptance in medical practice for a different approach to the professional standard so that legal reform may not be considered to be wholly controversial. Therefore, I would argue that it is an appropriate time to recommend Saudi Arabian medical law to move towards the prudent standard of care.

Having stated that, the prudent patient standard is an appropriate standard to be adopted by Saudi Arabian medical law, to avoid confusion and uncertainty, and this is most likely to be achieved by making changes in medical law regulation that will apply to all medical practitioners. In the Concluding Chapter, I will present the proposed standard of care and solutions to the current legal deficiencies of Saudi Arabian medical law by learning from English law experience.

Fifth, changing the standard of care would affect the role of SMPs. Courts in Saudi Arabia simply apply the law and do not go beyond what the law has stated.³⁰⁵ Thus in terms of information disclosure for the moment SMPs are bound to apply the professional standard of care as that is what LPHP2005 has stated and recognised.³⁰⁶ Therefore, any change would need to come from the law itself. If LPHP2005 adopts the prudent patient standard, SMPs will examine, consider and establish doctors' liability for the failure to provide the patient with the required information based on what a reasonable person in the patient's position would want to know. SMPs would therefore be more involved in judging medical evidence

³⁰⁴ For examples, A Adlan 'Informed Consent in Saudi Arabia', H Al-Faleh *et al.* 'Detailed Disclosure to Saudi Arabian Patients on Risks Related to an Invasive Procedure', A Mobeireek *et al.* 'Information Disclosure and Decision-making: The Middle East versus the Far East and the West' and K Saeed 'How Physician Executives and Clinicians Perceive Ethical Issues in Saudi Arabian Hospitals'.

³⁰⁵ See Chapter two for further discussion.

³⁰⁶ LPHP2005 article 26.

and establishing doctors' liability, rather than being so reliant on expert views to establish the standard of care. SMPs could judge the evidence more from the patient's perspective.

Generally, judges in Saudi Arabia do not have the power to establish precedents; rather, their role is to apply laws that are issued by the government.³⁰⁷ Their role in Saudi Arabian courts generally and in SMPs specifically in evaluating the expert evidence has been set by the law. LPSC2013 stated that: 'The experts' opinion is not binding on the court, which merely uses it as a guide'³⁰⁸ nonetheless, if judges do not accept the experts' evidence they must justify their rejections.³⁰⁹

Therefore, judges in Saudi Arabia have the power and authority to examine and investigate the expert evidence and either accept or reject it after providing reasons where it is rejected. At present, judges cannot ask or instruct medical experts to examine doctors' behaviours or duties of care from the point of view of the prudent patient standard of care, because that would go against what LPHP2005 has laid down. SMPs can reject medical evidence, but only if this can be clearly justified.³¹⁰ Even then, if SMPs reject the medical experts' evidence that decision can be overruled by the Administrative Court of Appeal³¹¹ if there is, for example, an accepted body of opinion which supports the defendant. Thus, if there is no robust and defensible reasoning for the rejection, the SMPs decision not to accept the medical experts view is invalid.³¹² Specifically, in relation to medical cases the issues become more complex, especially since most cases involve very sensitive and complicated matters and practical and professional matters that cannot be easily identified by an average person. Thus the role of the medical experts' evidence becomes more important as judges may not have the qualification to investigate and examine the reason behind the medical behaviour in question.³¹³

There are therefore two major problems with the current system in Saudi Arabia. First, the SMPs' makeup is such that decisions are taken with input from other healthcare professionals and are not solely reliant on the disinterested decision-making that can be expected of the judiciary, even in cases where the issues are complex and will certainly be

³⁰⁷ See Chapter two.

³⁰⁸ LPSC2013 article 138.

³⁰⁹ *Ibid*, section 1 in the executive regulation. (Arabic).

³¹⁰ *Ibid*.

³¹¹ LPHP 2005 article 35.

³¹² M Alqhatani *Alndam AlSaudi LeMzawlat Mehant Altab AlBasheri wa Tab AlAsnan (The Saudi Arabian law of Practicing Medicine and Dentistry Professions)* p. 126.

³¹³ *Ibid*. p127.

informed by medical evidence. Second, as the law currently stands, SMPs have no option but to apply the professional standard. While the latter problem would be alleviated by law reform in this area, the former problem will remain unless the responsibility for adjudication is transferred to a judicial rather than a quasi-judicial forum.

The fact that doctors sit as judges in SMPs raises a question mark as to the objectivity of SMPs. As I have argued elsewhere,³¹⁴ SMPs jurisdiction should be moved to specialist courts of law and judges with *Sharia* and legal qualifications should lead the courts, not medical professionals.³¹⁵ Therefore, the Saudi Arabian government, in order to achieve objectivity and to protect patients' rights and autonomy, should abolish SMPs and move their jurisdiction to specialist courts. LJ2007 has authorised the Supreme Judicial Council to establish a specialist circuit or panel (consisting of a judge or three) in any General Courts around the country for a specific matter.³¹⁶ For example, there are several Traffic Circuits in the General Courts around the country to apply the Traffic Law 2007.³¹⁷ Thus, I would strongly recommend that the Saudi Arabian government considers abolishing SMPs in reforming LPHP2005 as patients' rights and autonomy should be more protected.

5. Conclusion

While there seems to be some acknowledgment by the current Saudi Arabian medical law of respect for patient autonomy, that seems to be undermined by the emphasis on the professional standard of care. This, I would argue seems not to reflect Islamic *Sharia*'s recognition of respect for patients' autonomy and choices as long as they are in accordance with its traditions.³¹⁸ Hence, the current stance by Saudi Arabian medical law does not give sufficient weight to Islamic *Sharia*'s aim to provide protection for patient autonomy. Changing to a prudent patient standard would both offer that protection and be in harmony with Islamic *Sharia*'s requirements to respect patients' autonomy and should be imposed by the law. Further, in this Chapter the other main focus was on the matter of the legal deficiencies of Saudi Arabian medical law, as a result of applying the professional standard of care to information disclosure.³¹⁹ I have closely considered the current Saudi Arabian

³¹⁴ K Alghamdi '*Tatowr Tanzim Mahnat Altab wa Alsidalh be AlMammlakh Alarabeih AlSaudih*' 'The Development of Saudi Arabian Medical and Pharmaceutical Professions' Regulations'

³¹⁵ *Ibid.* p 93-94

³¹⁶ JL2007 article 19.

³¹⁷ Traffic Law 2007 article 81.

³¹⁸ See Chapter two for further discussion.

³¹⁹ Interestingly, the Law of Ethics of Research on Living Creatures 2010 (ERLC2010) recognised the term 'informed consent' as LERLC2010 in article 11 stated that '[n]o researcher may conduct research on any human subject prior to obtaining an *informed consent* from him or from his guardian in accordance with procedures specified by the

professional standard of care and its application, and it is clear that neither LPHP2005 nor CEHP2013 have adequately considered a number of issues which included the amount of information and the of type risks that should be disclosed to competent adult patients; the doctors' legal duties to inform the patient about the available alternative treatments; the legal duty to answer the patients' questions and how they should be answered; whether doctors have a legal duty to ensure that the patient can understand the information provided and the application of therapeutic privilege.

These deficiencies lead to confusion and uncertainty, as the thesis has above discussed. By examining the current practice of the professional standard of care under Saudi Arabian medical law against the thesis proposed ethical standard developed in Chapter two for Saudi Arabia, it is clear that the current practice fails to meet this standard.

I have argued that Saudi Arabian medical law should depart from the professional standard of care because the current legal deficiencies undermine respect for the patient's autonomy which is required in accordance with Islamic *Sharia*. I have concluded in Chapter two that Islamic *Sharia* has accepted to some extent the notion of the principle of respect for the patient's autonomy. I have supported my argument to do so by the understanding of Islamic *Sharia* medical ethics and general principles. Additionally, I have supported my argument by presenting some of the current studies which show that both medical professionals and patients in Saudi Arabia have acknowledged the notion of informed consent and the need for respect for the person's autonomy.

Thus, for these reasons in the Concluding Chapter I will suggest that Saudi Arabian medical law adopt the prudent patient standard of care based on the English law experience. That I believe would help Saudi Arabian medical law to clarify the current legal deficiencies that I have discussed in this Chapter, by learning from English law experience. English law used to adopt the professional standard of care, which is still applicable by Saudi Arabian medical law. Thus, English law's move to the prudent patient standard may be used to recommend that Saudi Arabia can do the same. This would require not only an adoption of the new standard but also a recasting of the judicial decision-making constitution and process.

Regulations' (Emphasis added). Then LERLC2010 in article 12 added that '[u]pon obtaining the informed consent, the researcher shall clearly explain to the human subject or his guardian all potential outcomes of the research including harmful ones, if any, which result from withdrawal of the informed consent.' (Emphasis added). However, the LERLC2010 in article 13 emphasised that '[t]he informed consent shall be documented in accordance with conditions and procedures specified by the Regulations.' At

<https://www.boe.gov.sa/ViewSystemDetails.aspx?lang=en&SystemID=280&VersionID=260> (accessed 28/06/2015)

The Concluding Chapter

1. A summary of the thesis

This thesis has undertaken a comparative study from an ethical and a legal perspective of the appropriate standard of information disclosure by doctors to competent adult patients. It has considered the approaches that have been developed in Saudi Arabia and in England, with the aim of proposing reforms to the current legal approach in Saudi Arabia. It has been contended that the legal standard of care that applies in Saudi Arabia is currently a professional based standard and that there are critical legal deficiencies in the way that the law currently approaches disclosure of information to patients. These include a lack of clarity about the role of expert evidence and the courts in establishing a breach of the duty of care; the extent to which risks and alternative treatments need to be disclosed; the duty to answer patients' questions; the need to ensure patients' understand the information given and whether there is a therapeutic exception to withhold information. In addition, as a more fundamental issue, this thesis has examined the underlying ethical values that the legal approach ought to be seeking to protect in order to propose reforms. Saudi Arabia is governed by Islamic *Sharia* and its laws must be consistent with these principles. However, Islamic *Sharia* allows the experiences of other jurisdictions to be considered and adopted if they are in accordance with its own principles or do not conflict with them. I have therefore undertaken a comparative study in order to learn from the experiences of England which has given detailed consideration to the kinds of issues raised by this thesis.

It was necessary to discuss in **Chapter one** the Western perspective on ethical principles, mainly the principle of respect for autonomy and the notion of trust. The reason for this discussion was to examine what values underpin seeking consent to treatment and information disclosure and to provide a basis for considering how well English law has protected these values. Chapter one studied the philosophical basis for the principle of respect for autonomy, particularly the work of Mill and Kant. It also discussed how the principle has been applied and developed in medical practice. The essential elements for a decision to be considered to be autonomous were considered, namely: competence, voluntariness and, most importantly, information disclosure. The role of consent as an expression of the individual's will was established.

Chapter one also considered the notion of trust as another approach that might place an ethical duty on doctors to inform their patients. The Chapter concluded that the notion of trust would not adequately protect the patient's need for information, because it depends on an imbalance of power between doctors and their patients. It might justify doctors deciding

what to disclose to patients regardless of the patient's values and wishes, based on the doctors' own views of what was best for them. Thus, this imbalance of power, which is at the heart of the concept of trust, would retain the idea of paternalism which it has been argued no longer has a central place in the current climate of respecting patient autonomy and choices. While doctors undoubtedly have an ethical duty to act in their patient's best interests and to avoid harming them, ethical medical practice is not confined to securing, so far as possible a 'good' medical outcome. It is now regarded as an essential part of ethical medical practice to respect competent adult patient's choices even if this may result in harm to the patient's health or even death. Although Chapter one has observed that the concept of autonomy is still subject to different interpretations and understandings, it has become an essential concern in Western medical ethics in regard to patients' consent and information disclosure.

The principle of respect for autonomy imposes an ethical duty on doctors to respect patient choices and to supply patients with adequate information. As an ethical ideal, since the principle is concerned with the protection of individual patient autonomy, it could be suggested that a patient should be given all information that enables that patient to be self-determining and make a decision that is in accordance with his/her own values, goals and beliefs. Too little information and patients are not adequately informed; however, too much and it may be difficult to understand or to determine what is relevant to their decision. Therefore, the thesis proposed an ethical standard based on the principle of respect for autonomy which requires doctors to disclose sufficient and understandable information to enable competent adult patients to be self-determining. It does not therefore propose that all available information should be disclosed but it does require that the patient understands the information given.

Having set out this as the appropriate ethical standard to apply to information disclosure, Chapter three went on to look at the extent to which English law meets this standard. I first sought to examine the ethical principles that have contributed to the development of English law on information disclosure. This examination highlighted the significance of the principle of respect for autonomy and how this has come to assume dominance in Western philosophy and Western medical ethics, largely replacing a paternalistic approach to the practice of medicine. I also considered the concept of trust and discussed its difficulties as a basis for founding a legal duty to disclose information. Following on from this, I concluded that the ethical approach that appears to be most appropriate to adopt is that:

Competent adult patients have a right to respect for their autonomy. Respect for their autonomy requires that their consent is needed in order for medical treatment to be given. In order for them to properly give consent, they need to be given sufficient information relevant to their decision and that they can understand.

Putting this another way, the thesis has proposed that patients should be provided with sufficient and understandable information to enable them to be self-determining. This conclusion was examined against English law in the Chapter three.

Chapter two explained the fundamental importance of Islamic *Sharia* to all aspects of life in Islamic countries and in order to assist understanding of this, the sources of Islamic law and different traditions of interpreting it were considered. The Chapter also argued that both Islamic *Sharia* and English law can learn some lessons from each other as there has been some evidence which shows some adoptions of some Islamic *Sharia* principles by English common law. Equally, Islamic *Sharia* can learn some lessons from English law experiences with some adjustments to be consistent with its basic principles.

It was noted that Saudi Arabia follows a *Sunni* School of thought and the different approaches of some of the major *Sunni* scholars were outlined. It was also crucial to explain the relationship between Islamic *Sharia* and the legal system of the Kingdom of Saudi Arabia. From its inception as a sovereign state, it was declared that the Kingdom would be driven by, and would conduct itself according to, the teachings of Islamic *Sharia*. Thus, a law in the country should comply or not in conflict with Islamic *Sharia* traditions.

The influence of Islamic *Sharia* sources and scholars on the legislative process in Saudi Arabia was examined, as was their influence on medical ethics. Islamic *Sharia* sources have been and remain central to the understanding of religious, ethical and legal principles in Islamic countries, specifically Saudi Arabia. This Chapter, however, concentrated on the religious and ethical principles and the consequences of their breach.

Chapter two argued that Islamic *Sharia* has implicitly recognised the need for respect for autonomy and that decisions should be based on knowledge. This clearly indicates much that is in common with the ethical principles discussed in Chapter one and it can be used to assert that patients have a right to respect for their autonomous decisions about treatment and to be provided with information in order to make them. In addition to Islamic *Sharia*, there is a Saudi Arabian medical ethics guidance which has both an ethical and a legal status in CEHP2013. It is regarded as an important regulation and a source of guidance on the translation of some Islamic *Sharia* principles into medical practice in Saudi Arabia. It also supports respect for patients' autonomy.

However, respect for autonomy under Islamic *Sharia* and CEHP2013 is limited by other central principles, including the need to preserve and protect human life and health. There are five rulings or values concerning the degree or scale of permissibility of an action in Islamic *Sharia* which are: *Wajib* (obligatory), *Moharm* (forbidden), *Makroh* (blameworthy), *Mandob* (praiseworthy) and *Mobah* (indifferent).¹

The discussion in this Chapter showed that recognition of respect for the adult competent patient's autonomy is considered in a certain way in Islamic *Sharia* medical ethics. It has been argued that Islamic *Sharia* principles permit a competent adult patient the right of choice as to what may be done to his/her own body, as long as that treatment or operation is not otherwise forbidden or where refusal would lead to death or severe harm.² If Islamic *Sharia* principles would be breached, then respect for the competent adult patient's autonomy would be limited. This has consequences for the appropriate approach to seeking consent and for information disclosure

The need for a decision to be based on sufficient knowledge has been mentioned. In addition, in Islamic *Sharia*, the requirement for information disclosure as a means of respecting patient autonomy may also be justified by the concept of doctors needing to act with truthfulness and to provide appropriate and honest advice. In Chapter two I also examined the place of trust in Islamic *Sharia* and noted that it is regarded as significant, but that it should not be used to override the ethical importance of patients being enabled to make their own decisions and to be provided with information that they need to do so.

However, Chapter two has found that, although Islamic *Sharia* and Saudi Arabian medical ethics have placed an ethical duty on doctors to provide patients with information, they do not explicitly state an ethical standard of information disclosure. To this extent, I would suggest that reform is needed to address this. While the thesis is focused on legal reform, since CEHP2013 has both an ethical and legal role in regulating medical practice, reform of LPHP2005 would also need to include reform of this document. I have put forward an ethical standard that places a duty on doctors to provide patients with sufficient and understandable information to respect their autonomy and to enable them to be self-determining. So far, it has been argued that the approach taken in this standard is in line with Islamic *Sharia*, but in addition, all actions must be in harmony with Islamic *Sharia*. There may therefore be some greater limits on what can be consented to and what can be refused under Islamic *Sharia* principles. Unlike Western medical ethics, from which the thesis's proposed ethical standard

¹ See Chapter two for further discussion.

² *Ibid.*

was derived, Islamic *Sharia* has limited the protection given to patients' consent and refusal which is against its principles because it will cause death or severe harm to the person him/herself (except in incurable illness) or others, or where (even if the result is harmless in itself) it conflicts with Islamic *Sharia* teaching.³ Given that the reasons for requiring consent to treatment are so similar, it can be suggested that the legal standard of care that has been judged sufficient to meet the ethical standard in English law would also be appropriate to meet the ethical standard in Saudi Arabia, provided that any issues where there might be a conflict with Islamic *Sharia* are considered. As I have argued, even if Islamic *Sharia* takes a different view from Western ethics and English law on the issue of whether a patient's decision must be respected, this does not alter the need to provide patients with sufficient information in a way that they can understand in order to make a decision. Therefore, in respect of information disclosure, requiring that the laws in Saudi Arabia could be reformed in line with English law and still be in accordance with Islamic *Sharia*.

It was argued that according to Islamic *Sharia* principles, information that should be disclosed would include information about alternative available treatments, since without this the patient's decision would be based on ignorance. Another area the thesis has discussed in Chapter two was doctors' ethical duty under Islamic *Sharia* to seek to ensure that the patient can understand the information that has been provided. It was contended that CEHP2013 does not address either of these issues adequately.

Regarding the notion of withholding information, Islamic *Sharia* and Saudi Arabian medical ethics have recognised such a notion in rare cases, when that would cause serious harm to the patient. This is also consistent with the approach taken to justifying withholding treatment information in Chapter one.

Finally, I have argued that Islamic *Sharia* medical ethics recognise that a patient has an ethical duty to seek information which would include asking questions of the doctor. Further, it has recognised that the patient has the right to waive information and can refuse information.

As noted, the ethical standard in Islamic *Sharia* is surely not identical with the Western one as there are more limitations. For example, Islamic *Sharia* does not recognise or support full respect for autonomy to consent to or refuse treatment that is against its principles or would lead to death or severe harm (except the case of incurable illness). On the other hand, it can be said that many aspects are the same – respect for autonomy, the need for sufficient

³Ibid.

information to be a self-determining, the need for patients to understand the provided information, the rare exceptions to withhold information and the duty to response to questions fully and truthfully. Considering that, the thesis proposed ethical standard developed in this Chapter as follows:

Competent adult patients have a right to respect for their autonomy *as long as this is not in conflict with Islamic Sharia*. Respect for patient autonomy requires that their consent is *normally* needed in order for medical treatment to be given. In order for them to properly give consent, they need to be given information relevant to their decision and that they can understand.

This standard was examined against Saudi Arabian medical law in Chapter four to explore whether the current practice of Saudi Arabian medical law meets it. It is proposed that the law should be reformed in Saudi Arabian to move to adopt the first part of *Montgomery* standard; essentially, the prudent patient standard. It should be remembered that the standard that Saudi Arabian medical law adopts should be adjusted to be in a compliance with Islamic *Sharia*.

In **Chapter three**, the thesis discussed how English law has approached the need for a competent adult patients' consent to treatment and the consequences that follow from failing to meet the requirements for a legally valid consent. It also considered how English law has addressed the principle of respect for autonomy in terms of the legal requirements.

English law has recently paid considerable attention to the importance of respecting patients' autonomy. It provides protection both through criminal and civil law. Criminal law is less important to this thesis but the role of consent as a defence in some circumstances was considered. More focus was placed on civil law and the elements for a legally valid consent were outlined. These mirror the kinds of concerns that were addressed in Chapter one, such as the need for competence, voluntariness and adequate information disclosure. It has been clearly asserted that a competent adult patient has the full right to consent to medical treatment or refuse it for whatever reason the patient considers fit and it has even been said that a patient need not give a reason for refusing treatment.⁴ However, it was noted that English law has drawn a distinction between the kinds of information cases that will be dealt with in battery and those that will be dealt with in negligence. It was explained that if the patient was informed of the broad nature of the intended intervention, this was considered adequate to amount to sufficient information to avoid liable for battery on this ground. In

⁴Re T(*Adult: Refusal of Medical Treatment*) [1993] Fam 95 p. 102.

most cases, failure to provide adequate information does not fall below this level and most cases will proceed in negligence.

Negligence claims have a number of essential elements that the claimant must prove on the balance of probabilities: a duty of care, a breach of that duty and that damage was caused as a result of that breach. It was explained that this is not as protective of patient autonomy as a battery action could potentially have been but it was recognised that this distinction now appears settled.

A number of different models of possible legal standards of information disclosure were reviewed as part of an examination of the development of the standard in English law. These standards were: subjective patient; professional (reasonable doctor) and prudent patient.

It has been argued that the increased affirmation of the importance of respect for patients' autonomy as an ethical principle in medical practice can also be seen in the development of English law. The acknowledgement of this principle can be noted strongly in the recent Supreme Court case of *Montgomery*.⁵ This case made it clear that competent adult patients are expected to be enabled to make their own decisions about whether to accept proposed medical treatment and are entitled to be provided with information which will enable them to take those decisions.⁶ Information should be provided based on whether

‘a reasonable person in the patient’s position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.’⁷

There are only limited exceptions where doctors are entitled to withhold information that would otherwise be considered necessary to the patient: when the information would lead to serious harm to the patient.⁸ The fact that the patient might refuse treatment is not in itself a reason to withhold information.

The thesis has argued that the English law experience has demonstrated a similar move away from a standard of care based on professional expertise and judgement as has been the case in medical ethics, and that it has developed an approach which more appropriately protects the principle of respect for patient autonomy: a prudent patient standard.

Since the case of *Bolam v Friern Hospital Management Committee*⁹ set out the test for professional negligence the approach to the standard of information disclosure has been

⁵*Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

⁶*Ibid.* para 115.

⁷*Ibid.* para 87.

⁸*Ibid.* para 88.

⁹*Bolam v Friern Hospital Management Committee* [1957] 1 W.L.R. 582.

developed toward a more patient-based standard, to reflect the increased importance of the ethical principle of respect for autonomy. This development can be illustrated in the following stages:

The commencement stage was set by the so-called *Bolam* test in its basic form: ‘He [a doctor] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.’¹⁰

The stage of interpreting *Bolam*. In *Sidaway v Bethlem Royal Hospital Governors*¹¹ the issue of information disclosure was the central issue in the case. Although the Law Lords had different justifications for their views in reaching their judgments, the majority agreed to apply the *Bolam* test.¹² Lords Bridge, Keith and Templeman applied a modified *Bolam* test,¹³ whilst Lord Diplock advocated the *Bolam* test for all medical matters.¹⁴ Lord Scarman alone applied the prudent patient standard.¹⁵

The stage of the significant development to *Bolam*. In *Bolitho v City and Hackney Health Authority*¹⁶ the court added a condition to the *Bolam* test by requiring that the medical opinion which is presented to establish appropriate professional practice must be able to withstand ‘logical analysis’.¹⁷

The stage of moving to what a ‘reasonable patient’ wants to be told and the duty to disclose a ‘significant risk’ that was reintroduced by *Pearce v Untied Bristol Healthcare NHS Trust*.¹⁸

The stage of the patient-oriented standard. In this stage, more recognition has been given to respect for patient autonomy, as in *Chester v Afshar*¹⁹ where it became clear that patients should be warned about significant adverse outcomes or risks or the complexity of procedures based on a reasonable patient standard.²⁰

In the final stage, in *Montgomery v Lanarkshire Health Board*,²¹ the Supreme Court has moved explicitly to consider patients’ autonomy in its decision to move away from applying the professional standard of care and move towards a standard that is beyond the prudent

¹⁰ *Ibid.* p. 587.

¹¹ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871.

¹² *Ibid.*

¹³ For example, *Pearce v Untied Bristol Healthcare NHS Trust* [1999] E.C.C. 167, where Lord Bridge’s view was applied.

¹⁴ For example, *Gold v Haringey Health Authority* [1988] Q.B. 481 and *Blyth v Bloomsbury HA* [1993] 4 Med. L.R. 151, where Lord Diplock’s view was strictly applied.

¹⁵ See Chapter three for further discussion.

¹⁶ *Bolitho v City and Hackney Health Authority* [1998] A.C. 232

¹⁷ *Ibid.* p. 241-242.

¹⁸ *Pearce v Untied Bristol Healthcare NHS Trust* [1999] E.C.C. 167.

¹⁹ *Chester v Afshar* [2004] UKHL 41

²⁰ *Ibid.* para 16.

²¹ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

patient standard of care,²² although it should be remembered that, for the reasons I have stated in Chapter four, the thesis will only recommend the first part of the *Montgomery*'s standard (the prudent patient standard).

It should be noted that, as the thesis has argued in Chapter three, *Montgomery* seems to set out two tests; first the traditional prudent patient test that is in line with Lord Scarman's view in *Sidaway*²³ when His Lordship adopted the view in the American case of *Canterbury v Spence*.²⁴ The Supreme Court has stated that for examining the materiality of a risk this is stated to be: '... *whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk...*'²⁵ (Emphasis added).

Second, it also seems to have adopted the Australian High Court's test in *Rogers v Whitaker*,²⁶ as the Supreme Court additionally added to the traditional prudent patient test that a material risk may also be what '...*the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.*'²⁷ (Emphasis added).

Thus, based on the second part of the Supreme Court's view, it can be understood that, in the case where the particular patient would attach significance to the risk, but a reasonable person in the patient's position might not, a doctor in this case is required to disclose that risk to the particular patient if the doctor '*is or should reasonably be aware*' of its relevance. This shows that the test of material risk in this second part is not a subjective test, as it is subject to the doctor's reasonableness in not being aware about the significance of the risks to that patient. The test in *Montgomery* seems to go beyond a simple prudent patient standard to examine the risk's materiality.²⁸

It must be borne in mind that there are still some uncertainties after the decision in *Montgomery* in regard to the issue of who is the reasonable person, disclosing alternative treatment and patient understanding of information. Regarding the uncertainty of the issue of disclosing alternative treatment, it seems that the English law model recognises a legal duty on doctors to inform the patients about available alternative treatments, although *Montgomery* has not attempted to identify or state guidance as when alternative treatments should be disclosed.²⁹ But as I have argued in Chapter three, the Supreme Court has brought

²² *Ibid.* para 87.

²³ *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 889.

²⁴ *Canterbury v Spence* (1972) 464 F.2d 772.

²⁵ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 87.

²⁶ *Rogers v Whitaker* (1992) 175 CLR 479.

²⁷ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 87.

²⁸ See Chapter three for further discussion.

²⁹ See Chapter three for further discussion.

the law closer to the GMC's guidance which might assist in clarifying that. Another issue *Montgomery* has emphasised is the legal duty to answer patients' questions, it has reinforced Lord Bridge's view in *Sidaway* to that doctor's must answer the patient's questions fully and truthfully.³⁰ English law has also recognised in general that doctors should take all reasonable steps to seek to ensure that the provided information can be understood by the patient,³¹ although there is still uncertainty in *Montgomery* as to how doctors should fulfil this duty. Having reached these conclusions, in summary, it is argued that the first part of the test of the materiality of a risk in *Montgomery* is in line with Lord Scarman's view in *Sidaway* when he argued for the application of the prudent patient standard. His Lordship's view seems to meet the thesis's proposed ethical standard of care, as it is difficult for the law to impose a purely subjective patient standard of care.³² Thus, I would agree with Lord Scarman's view and justification that the prudent patient test is the next best test to be applied because on the one hand it gives more protection and respect for patients' autonomy and reflects their wishes and values, on the other hand, it can be applied by the law.

Having established the approach that English law has now taken and concluded that it meets to a large extent the ethical standard that was proposed, the thesis then turned to a consideration of how Saudi Arabian medical law has dealt with the issue of information disclosure. Having discussed the thesis's proposed ethical standard and based on the conclusion of Chapters two and three, in **Chapter four** the thesis discussed the development of consent law based on Islamic *Sharia* and Saudi Arabian medical laws. It was noted that while the law in Saudi Arabia is based on Islamic *Sharia*, which prescribes some legal penalties, others are a matter of discretion for the courts, legislative bodies, and scholars. Islamic *Sharia* sources have been supplemented by legislation. It has shown that both Islamic *Sharia* and legislation give legal protection to the person's bodily integrity, as dealing with a person's body without his/her consent is a crime of assault. In terms of medical treatment, it is clear that generally the right of consent and refusal belongs to competent adult patients, but compared with English law, under Islamic *Sharia* and Saudi Arabian laws the competent adult patient has a more limited right to have his/her decision respected since actions must be in compliance with Islamic *Sharia*. This means, that in some cases a decision about medical treatment need not be complied with, in accordance with the principles set out in Chapters two and four.

³⁰ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 54 and *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 A.C. 871 p. 898.

³¹ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 90 and *AlHamwi v Johnston* [2005] EWHC 206 (QB) para 69.

³² See Chapter three for further discussion.

However, failure to obtain the patient's valid consent would normally attract both criminal and civil liabilities. It is rare for doctors to have a criminal intention to administer treatment without consent or against the patient's will in order to cause harm to the patient. However, Saudi Arabian law still holds that it is an offence for a doctor to not comply with LPHP2005 by treating without a valid consent or refusal (unless the treatment falls under the rulings of being *Wajib* or *Moharm*). Therefore, if a doctor mistakenly or negligently treats without consent, his/her action will not be treated as a crime of assault as the doctor does not have the criminal motive to force treatment upon the patient in order to cause an injury. Instead, the action will be treated as an offence of not complying with LPHP2005.³³ A patient who suffered a damage/injury as a result of the doctor's action will also be entitled to a civil remedy under Islamic *Sharia* and LPHP2005 principles.³⁴ This will be the case whether the treatment was provided intentionally against the patient's will or where consent was not obtained due to negligence or a mistake in failing to obtain it.

Thus, it can be said that Saudi Arabian medical law supports to some extent patients' autonomy and in particular respect for bodily integrity. Apart from where consent has not been obtained, another form of protection by LPHP2005 to consider the patient's autonomy, is when a doctor failed to inform the patient at all or failed to meet the professional standard to inform the patient, the doctor will be subject to a fine as he/she breached LPHP2005 and the patient will be subject for civil remedy if a damage/injury is resulted from the doctor's action.³⁵

As in Chapter three, Chapter four focused on doctors' civil liabilities and the elements for a legally valid consent were outlined. The issues that were addressed in Chapter three regarding the elements of a valid consent were revisited in this Chapter: competence and capacity, voluntariness and adequate information disclosure. Further, the issue of negligence was discussed. For a claim in negligence, to establish that the information given is below the appropriate standard of care there must be: a duty of care, a breach of that duty (*AlTaadi*), damage (*AlDarar*) and causation (*Allfdha*).

Regarding current Saudi Arabian medical law practice, Chapter four argued that the professional standard is the current standard of care which is applicable to all medical affairs, similar to Lord Diplock's version in *Sidaway*. That can be understood, as I have argued in Chapter four, from article 26 in LPHP2005, which states in general that doctors should

³³ See Chapter four for further discussion.

³⁴ *Ibid.*

³⁵ LPHP2005 articles 27 and 30. See Chapter four for further discussion.

conduct their duties of care in accordance ‘with commonly established professional standard’.³⁶ Thus, as this is the only reference in LPHP2005 regarding the standard of care, it can be argued that the professional standard is applicable to all medical cases. This recognition by LPHP2005 of the professional standard, as I have argued in Chapter four, shows that, although LPHP2005 seems to acknowledge the respect for patients’ autonomy, it has failed to fulfil that recognition through the current standard of care. Thus, LPHP2005 should replace the professional standard by the prudent patient standard to fulfil its commitment to protect patients’ autonomy in accordance with Islamic *Sharia*.

Further, I have argued that the current practice of disclosing information and risks in Saudi Arabia suffers from considerable legal deficiencies. I have highlighted the problem areas as follows: the lack of detail on the level and type of risks that should be disclosed to competent adult patients; the lack of recognition of the doctors’ legal duty to inform the patients about the alternative treatments that are available; the failure to address the doctors’ duty to answer patients’ questions and how they should do so; the legal absence of the doctors’ duty to seek to ensure that the patient can understand the provided information; the lack of clarity of the application of therapeutic privilege.

I would argue that this lack of clarity is because Saudi Arabian medical law has empowered doctors to set the standard of what information should be disclosed and has not intervened to set a more rigorous standard by itself. Throughout this Chapter there have been many points which show that Saudi Arabian medical law has relied on the professional practice of doctors. For example, SMPs utilise the professional standard of care to establish the failure of a doctor to disclose information or risks.³⁷ This current practice by Saudi Arabian medical law is very similar to what used to be applied by English law through the standard of care that commenced with the *Bolam* test, which was used to establish a doctor-based standard of disclosure. Further, by identifying the additional legal deficiencies that Saudi Arabian medical law is suffering from, it seems that the application of the professional standard has undermined the respect for the patient’s autonomy on a wider range of specific issues. An emphasis on the professional standard of care fails to protect patients’ basic rights under Islamic *Sharia*, which includes respecting their autonomy. I have concluded that the current practice in Saudi Arabian medical law seems to fail to meet the thesis’s proposed standard of care, as it does not currently set a legal duty to provide patients with sufficient and

³⁶ Ibid. article 26.

³⁷ See Chapter four for further discussion.

understandable information to enable them to be self-determining in making their decision, in accordance with Islamic *Sharia* principles.

Additionally, as I have argued in Chapter four, the time seems appropriate to propose such reforms, as there is a growing demand from patients for respect for patient autonomy in the healthcare setting, which supports a move toward the notion of informed consent.³⁸ As AlBar and Pasha have argued, patients now in Islamic countries' hospitals have become more aware of their rights and the notion of respect for their autonomy.³⁹ The prudent patient standard seems to be in accordance with in Islamic *Sharia* as I have argued in Chapters two and four so this approach would give more protection of the right to patient autonomy.⁴⁰

Therefore, I have proposed in Chapter four that Saudi Arabian medical law should depart from the professional standard of care and adopt the prudent patient standard of care as set out in the first part of *Montgomery*. This leads to the following question: based on the English law experience, what kind of specific reforms would this thesis suggest Saudi Arabian medical law should adopt?

Given that I have concluded in Chapter three that English law now has developed a more appropriate approach to information disclosure and that the approach adopted can be seen to be consistent with Islamic *Sharia*, the basis for my proposals for reform is that the prudent patient test should be adopted in Saudi Arabian medical law. If this approach is adopted it will require reform both to the legislation and codes of practice that currently govern this area, and to the way in which the courts use medical evidence.

It should be remembered that, unlike the English legal system, the Saudi Arabian legal system in general does not consider precedent law as an approach to establish or reform or develop law, the legal system entirely relies on legalisation that is based on or not in conflict with Islamic *Sharia*.⁴¹ Thus, the reform and development of medical law cannot be determined by courts of law (SMPs); it must be undertaken by the legislative bodies in Saudi Arabia.

³⁸ For example, H AlFaleh *et al.* 'Detailed Disclosure to Saudi Arabian Patients on Risks Related to an Invasive Procedure', M Abolfotouh and A Adlan 'Quality of Informed Consent for Invasive Procedures in Central Saudi Arabia', M Khedhiri, A Adlan and M Abolfotouh 'Informed Consent in Clinical Care: Models of Patients' Satisfaction and Attitude Based on General Trust and Risks Disclosure' and M Hammami *et al.* 'Patients' Perceived Purpose of Clinical Informed Consent: Mill's Individual Autonomy Model is Preferred'.

³⁹ M AlBar and H Pasha *Contemporary Bioethics Islamic Perspective* p. 111.

⁴⁰ See Chapter four for further discussion.

⁴¹ See Chapter three for further discussion.

2. Proposed Reforms

Reforms to the law in Saudi Arabia should be made to give greater legal recognition to the need for respect for patient autonomy, in so far as this is in line with Islamic *Sharia*. This thesis proposes that Saudi Arabian law should learn some lessons from the English law experience which has already developed greater respect for patient autonomy from a position that was very similar to that which is now applied in Saudi Arabia. There are therefore a number of aspects of the English law approach that can be recommended to be adopted to reform Saudi Arabian medical law.

2.1. The standard of care in information disclosure

It should be noted that this thesis is limited to reforming the current Saudi Arabian medical law by learning from English law experience; thus, the thesis will not suggest reform to English law or a solution to the uncertainties in the current decision of the English law case of *Montgomery*.

Therefore, I would suggest Saudi Arabian medical law should amend the current LPHP2005 (and as a result of that CEHP2013 will also require amendment) by introducing the prudent patient standard of care as it has been stated in the first part of *Montgomery* test.

Thus, Saudi Arabian medical law should replace its current reliance on the professional standard of care set out in article 26 of LPHP2005 by adopting the first part of the test in *Montgomery*. The test in *Montgomery* is that the amount of information and risks that should be disclosed to competent adult patients is based on the materiality of the risk, which is to be determined as follows,

‘The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient’s position would be likely to attach significance to the risk,’⁴²

At present, the standard of care in article 26 of LPHP2005 is as follows:

‘A healthcare professional governed by this Law [LPHP2005] shall exert due care in line with commonly established professional standard.’⁴³

Therefore, the thesis would propose the following formula to be adopted by LPHP2005:

Doctors must disclose relevant and material information about treatment and the risks that a reasonable patient would want to know in order for him/her to make an informed decision whether to consent to or refuse medical treatment. This relevance and materiality of information is to be judged from the perspective of the reasonable patient not from that of accepted medical practice.

⁴² *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 87.

⁴³ LPHP2005 article 26.

This does not disturb the general principle set out in article 26, but it limits its application in respect of information disclosure. This will be a clear ‘revolution’ to adopt a standard of care that gives more respect to patient autonomy, and is in accordance with the Islamic *Sharia* tradition. Since the fundamental respect for autonomy is already espoused by academic writers and is not against the principles of *Sharia* law, there should be no difficulty in accepting and adopting the proposed standard. More difficult will be its translation into law, given the nature of the Saudi Arabian legal system. However, it should be noted that it took English (and other) law some considerable time to mature into the prudent patient standard; that it may also take some time to change Saudi Arabian law is not, therefore, a barrier to advocating for change, and eventually realising it.⁴⁴

Acceptance and implementation of the proposed standard is called a ‘revolution’ here because it should be remembered that this recommendation would need to proceed through the Saudi Arabian legislative process for amendment of an Act as I have discussed in Chapter two. This proposed standard would be reviewed and discussed in the Saudi Arabian legislative bodies (the Council of Ministers and *Shura* Council). Although I have argued that the prudent patient standard is highly likely to be accepted by Islamic *Sharia* and it is appropriate as it gives more protection to patient autonomy, the final say on accepting or rejecting the adoption of the prudent patient standard in legislation is for the Saudi Arabian government.

However, the adoption of the prudent patient standard does not mean that the standard should not be reviewed and developed and this would rely on how SMPs (or an alternative tribunal) in Saudi Arabia apply and interpret it, and ultimately the potential for developing precedent through appeals to the Administrative Court of Appeal in the Board of Grievances. Further, the standard would be subject to consideration by scholars, academics and lawyers. Therefore, the issue should be opened up for debate and discussion as this aims to develop the standard in a way that is in accordance with Islamic *Sharia* and to give more protection to patient autonomy. In other words, the adoption of the prudent patient standard is the first step to reform LPHP2005 in order to clarify and develop principles that protect patient autonomy.

3. Recommendations to remedy other legal deficiencies

Having highlighted the most significant developments in English law for the standard of care, and based on the discussion in Chapter four that Saudi Arabian medical law needs can

⁴⁴ R Heywood ‘R.I.P. Sidaway: Patient-Oriented Disclosure — A Standard Worth Waiting for?’ (2015) 23(3) *Med Law Review* 455–466.

be reformed to give greater respect to the principle of autonomy, albeit in accordance with Islamic *Sharia* teaching.⁴⁵ Saudi Arabian medical law can learn from the current English law experience in respect of the specific issues related to information disclosure below. The following recommendations are made:

1. The legal duty to inform patients about available alternative treatments: Saudi Arabian medical law can learn from the decisions in *Montgomery* and *Birch v UCL Hospital*,⁴⁶ although it should be noted that, as I have stated in Chapter three and above, the extent of this duty is still uncertain under English law. Thus, the following formula is the same as in England, although there are problems with it and it will need further development in both countries. Therefore, the thesis would propose the following formula to be adopted by LPHP2005:

Doctors must disclose to patients any reasonable alternative or variant treatment.

2. The legal duty to answer patients' questions: Saudi Arabian medical law should learn from the decision in *Montgomery*, which approved Lord Bridge's approach in *Sidaway*. Therefore, the thesis would propose the following formula to be adopted by LPHP2005:

When the patient asks a question, doctors must answer that question fully and truthfully.

3. Information understanding: Saudi Arabian medical law should learn from the decision in *Montgomery* and *AlHamwi v Johnston*.⁴⁷ Therefore, the thesis would propose the following formula to be adopted by LPHP2005, considering that this formula is the same as in English law, although there are problems with it and it will need further development in both countries:

Doctors should take all reasonable steps to seek to ensure that the provided information can be understood by the patient.

4. The therapeutic exception: Saudi Arabian medical law should learn from the decision in *Montgomery* and Islamic *Sharia*. Therefore, the thesis would propose the following formula to be adopted by LPHP2005:

The application of a therapeutic exception should be used only in circumstances where disclosure would cause serious harm to the patient. Additionally, in the case where the patient has an obligation to consent to or refuse treatment the application of the therapeutic exception to withhold information should not be used by doctors to deprive the patient from making an informed decision.

⁴⁵ See Chapter two for further discussion.

⁴⁶ *Birch v UCL Hospital* [2008] EWHC 2237 (QB).

⁴⁷ *AlHamwi v Johnston* [2005] EWHC 206 (QB).

5. With regard to providing information to a patient who does not want it: Saudi Arabian medical law can learn from English law experience and Islamic *Sharia*. Therefore, the thesis would propose the following formula to be adopted by LPHP2005:

If a patient has clearly expressed that he/she does not want to know about his/her condition or the risk involved in the condition or in any treatment, doctors should respect the patient's decision, although doctors should provide but not force basic information on the patient.

6. I would argue that, it is not sufficiently practical simply to depart from the professional standard of care and adopt the prudent patient standard. This departure also requires reforming the composition and process of decision-making in SMPs. The fact that the SMP decision-makers include doctors, suggests that appropriate application of the new standard may be problematic as it is a legal and not a medical standard. Thus, it is proposed that:

SMPs should be abolished and their jurisdiction should be moved to specialist courts of law. Further, that specialist courts must meet the LJ2007 requirements, to be composed of judges with *Sharia* and legal backgrounds not medical professionals.

4. Concluding remarks

In addition to the recommendations above, I would further emphasise that:

1. Both the Saudi Arabian Ministry of Health and SCHS should do more in terms of educating medical staff regarding legal and ethical issues, specifically patients' rights, consent and information disclosure. Further, Ministry of Health and SCHS should provide medical staff with all relevant principles and laws in a basic and clear form to be an easy guideline for them. That, I would argue, can be achieved by updating the ethical guideline (CEHP2013), which should contain clear instructions for the critical issues which daily face medical staff and patients, including the issues the thesis has highlighted. It is also necessary that CEHP2013 be brought into line with any recommendations for reform adopted in LPHP2005, since CEHP2013 is not only a source of ethical guidance for doctors but it has legal effect too. Since one of the aims of the thesis is to promote clarity and consistency of approach, it is essential that these two instruments are reformed together. Both the MoH and the SCHS should also educate patients and provide them with more and easier access to what they should know about their rights, such as obtaining their consent and their right to be provided with information.

2. I would encourage legal academics and Saudi Arabian scholars to undertake different studies and research to discuss and address the different issues in the area of Islamic *Sharia* and Saudi Arabian medical laws which have so far not been widely debated, such as the issue of information disclosure. This could include, for example, reviewing a wide range of

Muslim scholars and jurists' books to identify and verify medical principles and to format them into clear regulations. However, I would argue that it would also be beneficial if studies were made to compare different legal systems, to present and demonstrate different analyses that have previously not been considered in Saudi Arabian medical law literature. While not advocating a wholesale adoption of the jurisprudence of other legal systems, since Saudi Arabia has a rich tradition of its own, such studies could be used to provide additional ways of considering issues and developing them in a way that remains consistent with the governing principles of Islamic *Sharia*.

3. Currently a draft Bill, entitled; Health Ethics Law (the Bill) is proposed by the Saudi Health Council⁴⁸ (SHC) The main aim of this Bill is to place ethical duties on health professionals (doctors, nurses *etc.*) and healthcare providers (hospitals, clinics *etc.*) in regard to public health, patients' rights, medical staff's duties and medical institutions' duties, to be enforced by law.⁴⁹

The Bill contains fifteen chapters. Most interesting is chapter three which is entitled 'Ethics Towards Patients'. This chapter focuses on how both medical professionals and healthcare providers should deal with patients and ensure that they are respected.⁵⁰ In the following I will consider and examine the articles that are related to the main focus of this thesis and its proposals for reform of the LPHP2005's deficiencies in order to evaluate whether the Bill has met the thesis's proposals or not.

3.1. The Bill has reintroduced the notion of respecting patients' choices and wishes,⁵¹ which has already been stated in LPHP2005 as I have explained in Chapter four. Hence, patients' choices should be respected as long as they are in accordance with Islamic *Sharia* and Saudi Arabian law. Thus the Bill has just reinforced a well-established principle, so it does not add a new principle. But I would argue that, this reinforcement shows that Saudi Arabian law gives some protection to respecting patients' choices and their rights.

3.2. In regard to the matter of information disclosure, the Bill has adopted the concept of 'informed consent'⁵² (*AlMowfaqh Almtabsserah*). This has been defined by the Bill as 'a consent that is given by a competent adult patient with his/her free will, and upon full

⁴⁸ The Saudi Health Council <http://www.chs.gov.sa/en/default.htm> (accessed 01/04/2016).

⁴⁹ The Bill article 2.

⁵⁰ Ibid. chapter three.

⁵¹ Ibid. article 5(1).

⁵² Ibid. article 1.

information and understanding of what is required from him/her, aiming to help the patient to make a free decision.⁵³

It is obvious that, the Bill has introduced the notion of patients' 'informed consent' to Saudi Arabian medical law.⁵⁴ Thus, I would argue that the Bill by adopting the concept of 'informed consent', which was not recognised by LPHP2005 and CEHP2013, represents the new stance of medical health authorities in Saudi Arabia in relation to the provision of more protection to patients' rights and autonomy.

3.3. The Bill has placed two ethical duties on medical professionals in order to obtain 'informed consent'; (1); they '...should provide clear and understandable medical information and explanations to the patient about his/her health conditions, the course of the treatment and advising the patient to follow the medical instructions and warn him/her of the consequences to not comply with that instructions.'⁵⁵

The other duty is that (2) medical professionals '...must not exceed a competent adult patient's informed consent [save in the case of emergency].'⁵⁶

Although the Bill seems to place and recognise ethical duties on medical professionals to obtain an 'informed consent' and not exceeding the scope of the patient's informed consent, (not recognised by LPHP2005 and CEHP2013), it seems that the Bill still suffers from some confusions and deficiencies. For example, it does not state clearly how medical professionals should fulfil these duties.

Although the Bill proposes that doctors have an ethical duty to use the simplest and most clear way to inform the patient, specifically in cases of terminal illness,⁵⁷ this, I would argue, seems to not be sufficient as it still falls short of stating which standard of care doctors should use in order to fulfil their ethical/and legal duty to obtain an informed consent.

3.4. The Bill has emphasised an ethical duty on medical professionals to obtain patients' consent in writing in any cases of medical operations.⁵⁸ This ethical duty is not mentioned in LPHP2005, but it has been already recognised by CEHP2013 as I have explained in Chapter four. So, again, the Bill has simply reinforced an existing duty.

⁵³ Ibid.

⁵⁴ The notion of informed consent is already recognised by Saudi LERLC2010, but for medical research. LERLC2010 has stated that an informed consent must be obtained in any medical research which involves humans. See footnote no 319 in Chapter four.

⁵⁵ The Bill article 8(1)a.

⁵⁶ Ibid.

⁵⁷ Ibid. article 8(1)b.

⁵⁸ Ibid. article 8(1)c(2).

3.5. The Bill has recognised patients' rights to withdraw his/her consent and this right has to be respected.⁵⁹ This right and the corresponding ethical duty on doctors were not stated in either LPHP2005 or CEHP2013.⁶⁰ Thus, I would argue that the Bill seems to give more protection to patients' rights and autonomy than did the previous legal position. This seems to be comparable to the judges' views in *Montgomery v Lanarkshire Health Board*,⁶¹ and other English law cases, where courts have begun to take ethical principles seriously in their judgments. Therefore, it can be argued that both legal systems seem to be driven by the same motive; namely, to pay more attention to the translation of ethical principles that protect patients' rights into legal principles. For example, the decision in *Montgomery* to uphold the prudent patient standard and the Saudi Health Council to frame ethical duties in a law.

With all due respect to the Bill, however, there are several important issues that have been missed. These issues are what I have highlighted in this thesis as significant legal deficiencies in both LPHP2005 and CEHP2013. Firstly, and most importantly, the Bill has not stated clearly which standard of care should be applied; that is, on what basis would doctors' failure to disclose certain information be judged? Is it the professional standard of care or other standards of care? It is neither sufficient nor adequate for the Bill simply to adopt the use of the concept of 'informed consent' with no mention of what standard of care should be applied.

Because, the usefulness of the term 'informed consent' is dependent on the standard of care that is applied by the courts, it is not necessarily associated with a specific standard of care.⁶² Hence, it can not be said that just adopting the term 'informed consent' is adequate to determine the amount of information and risk which should be disclosed. Thus, the standard of care that should be applied must be clearly stated.

Consequently, as the Bill does not state which standard of care should be applied, this will generate more confusion, because, courts in Saudi Arabia when the Bill becomes legally binding, will face a problematic question as what standard of care should be applied. Is it the professional standard which is stated by LPHP2005? Or because the Bill is a separate law might there be another standard of care, and if so what should it be?

The Bill therefore, should clearly state which standard of care for information disclosure should be applied. For the reasons I have stated throughout this thesis and as the Bill seems to acknowledge patients' rights, I would strongly recommend that the Bill should adopt the

⁵⁹ Ibid. article 9.

⁶⁰ See Chapter four for further discussion.

⁶¹ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 para 80-85

⁶² See for example, J Berg *et al. Informed Consent: Legal Theory and Clinical Practice* (2nd ed OUP 2001).

prudent patient standard as I have formulated above. This would avoid the same legal vacuums that applying the professional standard of care has generated in the current LPHP2005.

Secondly, the Bill unfortunately does not include or mention any ethical duties concerning; doctors' duty to disclose any available alternative treatments to patients, doctors' duty to answer patients' questions or doctors' duties to take all reasonable steps to seek to ensure that patients can understand the provided information. Other important matters that are missing in the Bill are; the applicability of the therapeutic privilege exception (which to some extent was considered in LPHP2005)⁶³ and finally doctors' duties when dealing with a patient who refuses to be informed.

Another problematic aspect of the Bill is that it follows the LPHP2005 pathway, by not considering handing jurisdiction in these matters to courts of law. The Bill empowers Ethical Panels (composed of healthcare professionals), under the supervision of the Legal Department in the SHC, to apply the terms of the Bill and to investigate, and judge health professionals and healthcare providers' actions.⁶⁴ Further, the parties can appeal the decision first to the Legal Department in the SHC,⁶⁵ then the Legal Department's decision can be appealed to the Administrative Courts within 30 days following their being informed of the Legal Department's decision.⁶⁶

Thus, I would argue that the composition of the Ethical Panels would raise the same question mark as to their objectivity as that which arises in the case of the SMPs. The Ethical Panels' composition is problematic, because their members are healthcare professionals. Not only might they be seen as sympathetic to their peers, they may also find it difficult to apply a legal standard without training in the law. These, deficiencies in the Bill are cause for concern, as has been shown throughout this thesis. Consideration of the proposals made in the thesis is strongly recommended before the Bill becomes final. Further, as I have argued above regarding the SMPs, the Bill should empower courts of law to apply the law; it would be unfortunate were the Bill simply to entrench the same problems as currently exist in terms of expert and disinterested decision-making

In conclusion, the Bill in its current form does not sufficiently and appropriately address the current deficiencies that the thesis has identified, and therefore provides no solutions to them.

⁶³ See Chapter four for further discussion.

⁶⁴ The bill article 88.

⁶⁵ Ibid. article 97.

⁶⁶ Ibid. article 98.

While progress is to be welcomed, a more radical approach would be needed to satisfy the aim of protecting patients' rights and demonstrating respect for their autonomy.

Finally, based on what has been discussed and argued for in this thesis, it is clear that the development of English law has demonstrated that the considerably increased attention to patients' rights has led the law away from reliance on the professional standard of care towards a prudent patient standard, which provides more consideration of some of the ethical principles that strongly safeguard patients' autonomy and their roles in making informed decisions. This movement by English law towards protecting patients' rights and autonomy can be traced clearly throughout the case law that was discussed in Chapter three.

Thus, since the protection of rights in general, and patients' rights specifically, is completely in harmony with Islamic *Sharia* and Saudi Arabian law, there is no reason for, nor is there a barrier to, Saudi Arabian medical law following the English law example, albeit that there are some limitations imposed by Islamic *Sharia* principles in regard to some aspects of patients' consent and refusal. Nonetheless, these limitations do not directly affect the development of an appropriate information disclosure standard such as that developed in English Law. As the thesis has shown, both legal systems are in total agreement in their expressed commitment to the protection of patients' rights.

Therefore, as has been argued in this thesis, a major benefit of endorsing the English law approach and learning from its experiences is that it requires clarification of the problems identified in this thesis both in the existing Saudi Arabian medical law and in the proposed new Bill (Health Ethics Law).

Remedying these problems will result in Saudi Arabian medical law achieving its goals of offering protection to the rights of patients to make an informed decision about their healthcare without negatively affecting medical practice.

While the thesis did not set out to consider decision-making institutions directly, a consequence of the argument here is that development of a clear legal standard also requires re-evaluation of the current SMPs that are charged with the responsibility of deciding on issues of liability.

Moving SMPs jurisdictions to courts of law comprising judges (with legal backgrounds) would give more assurance to patients that their rights to be informed will be appropriately protected and respected.

Thus, I would conclude that the arguments developed in this thesis would help not only to reform the current Saudi Arabian medical law (LPHP2005), but also would supply solutions to the problems identified in the proposed new Bill.

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