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briefcase on MEDICAL LAW

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Briefcase on Medical Law

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Preface

Medical law is a relatively new area of law. It draws on, and overlaps with, many other areas of law such as tort, family law, human rights and criminal law. Apart from this hybrid legal basis it is also informed by bioethical theory. This book draws those elements together to form a comprehendible and succinct overview. The cases—and other relevant material—will be linked by short comments that help to explain their legal relevance. A brief introduction to the ethical principles that govern the provision of healthcare will provide a framework for considering the issues that arise in the cases. This ethical framework will include discussion of the principles of autonomy, beneficence, non-maleficence, justice and veracity. Following this, relevant cases and important judicial *dicta* will illustrate the legal rules and principles of each key area of healthcare law. Relevant statutory material will be included as will appropriate extracts from professional bodies' codes of practice. Interspersed with the cases and materials 'think points' will be used to test the student's understanding and guide him/her towards the important and contentious issues.

The primary aim of this book is to provide a rapid and easy access to the important cases within the area of healthcare law. It will provide a valuable adjunct to more substantial texts as well as being an essential revision tool. It will also provide a useful springboard from which a student could dive into the deep waters of research. A secondary aim of the book is to provide a summary of healthcare law to students and practitioners of other disciplines. Doctors, nurses, other healthcare workers and bioethicists will all find the book a ready source of relevant case law and material written in clear English.

The author has made every effort to ensure that the law is correctly stated as of 31 January 2001.

Alasdair Maclean
May 2001

Contents

Table of Cases

Table of Statutes

Table of Statutory Instruments

Table of European Legislation

Directives

Treaties and Conventions

1 Medical Ethics

1.1 Ethical theories

1.1.1 Teleological theories

These theories are goal orientated or consequentialist. They aim to provide a theory for action based on the consequences of the act. The preferred alternative is the one that produces the most good and least harm. Teleological theories stress that it is the consequences of the act and not the motive behind the act that should be judged. Thus, they separate the moral judgment of the act from the moral judgment of the actor. Utilitarianism is perhaps the foremost example of a teleological theory. It combines two theses: (1) all actions and rules are judged solely by the contribution they make to increase human happiness or decrease human misery; (2) pleasure is the only thing that is inherently good and pain is the only thing that is inherently evil. Notable exponents of utilitarianism include Jeremy Bentham and John Stuart Mill. An important aspect of utilitarianism that Bentham argued for is that every person counts for one and no person for more than one.

Other consequentialists adopt a 'pluralist' approach and believe that things other than pleasure can be inherently good. Ross (1930) argues that at least four things are intrinsically good:

- pleasure;
- knowledge;
- virtue; and
- justice.

Specific medical goods might include: absence of disease; absence of pain or suffering; and a 'trust-filled' professional-patient relationship (Graber (1998)).

Because utilitarianism risks riding roughshod over the individual for the good of society some philosophers have incorporated deontological principles within a utilitarian framework. 'Rule utilitarianism' argues that such principles should be followed if institutionalisation of the principle

maximises welfare. In that case the rule should be followed even though there may be occasions when breaking the rule would maximise welfare. JS Mill, for example, argues that a respect for autonomy will maximise happiness. See, also, Hare (1981).

Think point

Consider whether utilitarianism supports the view that a person with two healthy kidneys should be sacrificed in order to allow two individuals with renal failure to lead normal lives?

1.1.2 Deontological theories

These theories are based on the premise that we owe certain duties to others. These duties may arise from the other person's right, such as a 'right to be informed' or from the idea of 'respect for persons'. Immanuel Kant is the most notable deontologist. Two important principles that Kant described are:

- treat both yourself and other people as ends and never simply as means to an end;
- only base your acts on maxims that you would want to be applicable universally.

The moral duties that derive from these principles act as constraints to the individual's actions that may be performed in pursuit of his goals. Examples of moral duties include: do not lie; do not kill another person; do not harm another person. Some deontologists believe that the most important moral duties are 'absolute' and cannot be overridden. This can lead to problems where moral rules conflict. The rules could be qualified but this weakens their value. Instead, other deontologists argue for *prima facie* duties, which means that where two moral duties conflict, their relative moral weights must be determined in order to give primacy to the more compelling rule. This is necessarily situation dependent. Ross lists seven fundamental *prima facie* duties:

- Fidelity.
- Reparation.
- Gratitude.
- Justice.
- Beneficence.
- Self-improvement.
- Non-maleficence.

In the medical ethics setting, Beauchamp and Childress (1994) lay down four essential principles:

- Autonomy.
- Beneficence.
- Non-maleficence.
- Justice.

Some medical ethicists would add a further principle to this list:

- Veracity.

1.1.3 Religious theories

Each religion has its own views on morality. Although secular ethics has evolved from the religious approach, it is not appropriate to consider them here as this book takes a secular approach. For a consideration of medical ethics from a Christian perspective, see Ramsey (1970).

1.1.4 Contractarian theories

Strictly speaking these theories are political but they are relevant to medical ethics—especially when considering resource allocation and other issues of Justice. Perhaps the most notable contractarian theory is Rawls' *Theory of Justice* (1972). This social theory requires a hypothetical Veil of ignorance' that prevents the individual from knowing his role in society-whether a leper or politician. From this impartial viewpoint Rawls argues that an individual would choose a system of justice with two main principles:

(1) each person should have a maximum liberty that is compatible with the same degree of liberty for everyone within the community; and
(2) an unequal distribution of 'goods' and resources would be unjust unless such a distribution improved the lot of the least advantaged.

1.2 Ethical principles

1.2.1 Autonomy and respect for autonomy

Autonomy literally means self-governance. There is no universal agreement as to its exact meaning and the term is often used interchangeably with self-determination. It is valued because it is through autonomy that our character is shaped. It is the exercise of our autonomy that makes us the person we are and provides us with our dignity.

Definitions include:

- 'The idea of autonomy is a blindingly obvious one. It simply means that if I am to act in an ethical or moral way I must choose for myself what I am going to do'—Charlesworth (1993).
- '…the capacity to think, decide, and act on the basis of such thought and decision freely and independently… In the sphere of action it is important to distinguish between…simply doing what one wants to do and, on the other hand, acting autonomously, which may also be doing what one wants to do but on the basis of thought or reasoning'—Gillon (1985).
- 'Autonomy is a second order capacity to reflect critically upon one's first order preferences and desires, and the ability either to identify with these or to change them in light of higher order preferences and values'—Dworkin (1988).
- '…freely and actively making one's own evaluative (requires true beliefs and rationality) choices about how one's life should go'—Savulescu and Momeyer (1997).
- '…personal rule of the self that is free from both controlling influences of others and from personal limitations that prevent meaningful choice, such as inadequate understanding. The autonomous individual freely acts in accordance with a self-chosen plan'—Beauchamp and Childress (1994).

Autonomy may be used in three senses (Mappes and Zembaty (1991)):

(1) Liberty (freedom) of action—lack of coercion, intentional action, voluntary action.
(2) Freedom of choice—implies a positive obligation on others to ensure that an adequate range of choices is made available.
(3) Effective deliberation—implies rational thought, the ability to form appropriate goals and determine how best to achieve those goals.

A distinction should be made between an autonomous person and an autonomous action. This is very relevant to the assessment of decision making capacity, which is a pre-requisite for the legal validity of consent. The English law of consent recognises this distinction since it protects any decision of an autonomous person. An autonomous person is one who is capable of acting autonomously but this does not mean that all of his actions will be autonomous. Beauchamp and Childress argue that an autonomous action has three components: (a) an intentional act; which is (b) based on an understanding of the circumstances; and (c) is without controlling influences. To this, it might be added that for an act to be autonomous it must be rational.

It is also important to note that autonomy is not an all or none characteristic. Individuals will possess a greater or lesser degree of autonomy. Even where the individual's autonomy is extremely limited, it is still important to respect that autonomy and to maximise it as far as possible. It should be borne in mind that one goal of medicine is to return the individual to their pre-illness level of autonomy. However, where the individual is incapable of making an autonomous decision then paternalistic intervention can be justified as it will promote or protect that individual's autonomy. In fact, respect for autonomy demands paternalistic intervention in situations where the individual lacks the requisite capacity. Paternalism is not justified where the individual has the capacity to make an autonomous decision even if the decision they make is not an autonomous one.

A respect for autonomy demands that both the State and other members of the community respect the decisions and actions of an autonomous person. This is not simply a negative duty of non-interference but also requires the positive obligation that choices are made available to the individual. However, autonomy and respect for autonomy are not absolute.

The negative duty of non-interference with another's autonomy may be justifiably constrained by liberty-limiting principles. The most widely accepted of these principles is JS Mills' 'harm principle' which states that the only justification for interfering with an individual's autonomy is where it prevents harm to a third party. Some authors, more controversially, would extend this to include the prevention of self-harm (Raz (1989)).

The positive obligation entailed by a respect for autonomy may be justifiably constrained by the following:

(1) this duty does not exist universally but requires a 'special relationship' between the parties. Such relationships exist between the State and the members of its community, between the professional and his client and between parent and child;
(2) this duty is owed equally to all individuals within the community and thus one person's choices cannot be legitimately promoted at the expense of another's;
(3) the duty only exists where there are sufficient resources available to make the choices meaningful;
(4) there is no duty to provide choices that are 'futile' and will not promote an individual's autonomous life plan. There is no obligation to promote the non-autonomous choices of an individual simply because he is autonomous;

(5) there is no obligation to promote an individual's autonomy if it compromises the promoter's moral integrity.

An individual's autonomy may be unjustifiably infringed or constrained by the following:

(1) coercion;
(2) misinformation—including lying;
(3) withholding information;
(4) restricting or not offering choices.

Additionally, internal factors such as illness, pain, strong emotion, inadequate mental capacity and mental disorders such as phobias or compulsive disorders may limit autonomy.

As a principle, the concept of autonomy provides a broad guide as to how to treat others. By considering the ways in which autonomy may be infringed it is possible to develop more specific rules based on autonomy. Beauchamp and Childress (1994) provide some examples of these more specific rules, which include:

- tell the truth;
- respect the individual's privacy;
- protect confidences;
- ensure that consent is obtained for medical interventions;
- when asked, help others to make decisions.

To this list may be added:

- make an adequate range of choices available.

Note

It is worth remembering that Kant's notion of autonomy was rational self-governance constrained by universal moral rules. Thus, an autonomous act is one that flows from a sense of universal moral duty and not from selfishness or self-interest. This is somewhat different to the more egocentric, modern 'Kantian' notion of autonomy (see Seeker (1999)).

1.2.2 Beneficence and non-maleficence

The BMA (1999) considers that: 'The primary goal of medicine is to benefit the patient by restoring or maintaining the patient's health as far as possible, maximising benefit and minimising harm.' Similarly, the Hippocratic Oath enjoins doctors to 'follow that system of regimen which, according to my

ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious'.

The principle of beneficence owes its origin to three influences: the Hippocratic Oath, the Good Samaritan Christian ethic, and the *Noblesse Oblige* ethic of the Order of the Knights Hospitallers of the Crusades (see Jonsen (1990)).

Put simply, the principle of beneficence is the moral duty to act for the benefit of others. It is a positive obligation that requires the provision of benefits, the prevention of harm and the removal of detriments such as pain or ill health. The obligation extends to all healthcare professionals by virtue of their professional role. Thus, a surgeon would be expected to perform the most appropriate operation for the patient rather than performing an alternative that they would prefer because it would be good experience for them and enhance their career. However, it would not require the professional to offer his own kidney for transplantation if none other was available.

Beneficence also exists as an imperfect obligation, which means that, outside of special relationships, it is morally good to act for the benefit of others but a failure to act in this way is not morally bad.

Beauchamp and Childress (1994) suggest a number of moral rules supported by the principle of beneficence:

(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.

Beneficence may be constrained by the choice of the autonomous person. If the patient refuses an intervention that the professional believes would be of benefit then the professional must respect that choice. A caveat is that the professional must ensure that the patient has all the necessary information and has given proper consideration to the issue. A contentious issue is whether the professional should override a non-autonomous choice made by an autonomous individual. Legally, the professional must respect the patient's choice but morally there is a strong argument for overriding a choice that will adversely affect that patient's future autonomy. A problem arises in this area in deciding what counts as a benefit. Should benefits be objectively or subjectively determined? If subjectively determined, should the patient or the healthcare professional determine what is a benefit? Traditionally it has been the physician who decides but this is a paternalistic approach that is no longer acceptable. It is disrespectful of the patient's autonomy not to take into account the patient's view of what constitutes a benefit.

Another constraint on beneficence is that of justice. The professional owes an obligation of beneficence to all of his patients. It might be unjust for the physician to provide the best treatment to one patient if it is so expensive that it uses up resources that would have benefited other patients.

Non-maleficence is simply the obligation not to cause harm. Because it is a negative obligation, it has a wider application and is universally applicable. Unlike beneficence, it is a perfect obligation. However, it may be trumped by other principles, such as beneficence, if the overall result is beneficial and maximises utility. This is the justification for surgical operations. The harm caused by the incision and removal or damage to tissue must be less than the benefit that the patient will receive from the operation. The decision as to what constitutes a net benefit is one that should be made by the patient with the expert advice of the professional. As the BMA (1999) states: 'Where the patient is competent, he or she is the best judge of what represents an acceptable level of burden or risk.' It is important to note that overriding an autonomous person's wishes is itself a harm irrespective of any physical harm that the treatment causes.

It is also worth noting that medical decisions involve a greater or lesser degree of uncertainty that may affect the balancing of harms and benefits. Consider a man with a gangrenous leg. Surgical amputation offers a good chance (though not 100%) of survival but with the certainty that the man will lose the affected limb. Medical treatment with antibiotics offers a much lower chance of survival (say 15–20%) but the man retains his leg and so will not be disabled. The patient is the only person who can provide a value rating for such a disabled life that will allow a proper balancing judgment to be made against the risk of death. The role of the healthcare professional is to assist the patient in making the decision and not to make that judgment for him. For this reason, beneficence and non-maleficence must be constrained by the wishes of the autonomous patient. The professional's duty of beneficence and non-maleficence in these circumstances is to ensure that the patient has made a truly considered decision.

Think point

Consider whether the principle of beneficence obliges healthcare professionals outside of their work place to assist persons at risk?

1.2.3 Justice

In this context justice refers to fairness or equity and not to lawfulness. Aristotle argued that an unjust act was one that caused the actor to gain more than their fair share. He distinguished two forms of 'particular justice' (*Nicomachean Ethics* (1953)):

(1) rectificatory justice—remedies an inequitable transaction between two parties; and
(2) distributive justice—remedies an inequitable distribution of community resources.

It is the second of these two types of justice that is most relevant to healthcare ethics. Aristotle believed that equals should receive equal shares and unequals should get unequal shares in proportion to their inequality. The judgment of equality should be based on some form of merit. Aristotle noted three different types that may be used:

- the democratic criterion of free birth;
- the oligarchic criterion of wealth or good family;
- the aristocratic criterion of excellence—this type of merit judgment would, for example, allow that an Olympic athlete should get preferential treatment to a 'fun runner'.

Another type of merit judgment that might be made is based on the criterion of 'need'. This raises the conceptual problem of what is meant by 'need'. Relevant factors in assessing need include:

- seriousness of illness or disability;
- capacity to benefit from the resources available—it would be unjust to give the last dose of an antibiotic to someone with a viral illness rather than to someone with a sensitive bacterial infection because the individual with the viral infection has no capacity to benefit from the antibiotic;
- likelihood of further harm or deterioration of the individual's condition;
- rapidity of any deterioration.

In making the judgments of equality or inequality, the Rawlsian system discussed earlier might be a suitable mechanism. By operating behind the 'veil of ignorance' there would be less tendency to make decisions based on criteria that act to our advantage.

Utilitarian justice aims to maximise overall welfare. Although JS Mill argues that each person counts for one and no one for more than one this does not mean that resources should be equally distributed. Instead, the aim is to maximise happiness regardless of its distribution amongst the

members of the community. Thus, Mill states: '…equal amounts of happiness are equally desirable, whether felt by the same or different people.' Take three persons: A, B, and C and 6 units of a resource, X. Let A gain 1 unit of happiness from each unit of X; let B gain 3 units of happiness from the 1st unit of X, 1 unit of happiness from the 2nd unit of X and none from any more units of X; and let C gain 1.5 units of happiness for the 1st three units of X followed by 0.5 units of happiness from the next 2 units of X and nothing for any more units of X. Consider distribution (1):

A: 2X=2 units of happiness.

B: 2X=4 units of happiness.

C: 2X=3 units of happiness.

The overall happiness produced is 9 units and is unevenly distributed even though the resource was shared equally. Consider distribution (2):

A: 3X=3 units of happiness.

B: 1X=3 units of happiness.

C: 2X=3 units of happiness.

Here the overall happiness is still 9 units but now it is evenly distributed although the resources were not. Finally, consider distribution (3):

A: 2X=2 units of happiness.

B: 1X=3 units of happiness.

C: 3X=4.5 units of happiness.

Now the amount of happiness is maximised at 9.5 units but neither the distribution of resources nor the distribution of happiness is equal.

From the perspective of utility, distribution (3) would be the most just. However, from the perspective of equality based on the capacity to benefit then distribution (2) would be the most appropriate. Distribution (1) would be favoured by a system that regards all men as equal and distributes resources accordingly.

1.2.4 Veracity

Traditionally, truth-telling has not received prominence in healthcare relationships. The argument is that a healthcare professional is justified in lying to a patient when the deception is used for the patient's benefit. Lipkin (1991) argues that: (1) telling the 'whole truth' is a practical impossibility; (2) patients are unable to interpret medical information accurately; and (3) patients do not always want to know the truth. This argument is still

recognised by English common law in its concept of 'therapeutic privilege' (see Chapter 2). The argument for deception is based on the principles of beneficence and non-maleficence.

Telling a patient about serious risks may prevent the patient from consenting to a procedure the doctor believes is in the patient's best interests. The concern is that the severity of the potential outcome is blown out of all proportion relative to the probability of the risk materialising. Why worry the patient with unlikely possibilities? The counter argument derives from the principle of autonomy, that is, the patient will be prevented from making a truly autonomous decision if they are not in possession of the relevant information. If they have been lied to about a particular risk then their autonomy has been constrained. It might be argued that lying will prevent the patient from making a decision they later come to regret but this fails for two reasons: first, there may be factors that the doctor is unaware of that are relevant to the decision and thus affect whether withholding the information is actually beneficial; second, failing to respect the patient's autonomy—as discussed earlier—is a harm in its own right that would need to be entered in the benefit-harm equation.

Another instance in which deception may occur is when the healthcare professional tries to 'protect' the patient from a poor prognosis. This is also unjustified for the same reasons as given in the first scenario. If a dying patient is not informed of this fact they may lose the opportunity to ensure their affairs are in good order and to say goodbye to loved ones. Furthermore, deception can lead to uncertainty, anxiety stress and depression. Also, in an ongoing relationship, a lie will necessitate further lies in order to maintain the deception.

Deception is also unacceptable, because it breaches the trust that is essential in the therapeutic relationship. Without trust, the relationship breaks down. The patient will be reluctant to divulge information or rely on the advice of a person that they do not trust. Trust and respect are the cornerstones of the therapeutic relationship and a lack of veracity erodes both of these.

One argument against telling the truth arises from the philosophical difficulty in ever being able to know what the absolute truth is. Most medical advice and decisions are based on probabilities and uncertainties. However, this objection to veracity falters if we add the caveat that the healthcare professional's duty is to honestly tell the truth as he believes it to be based on the available evidence.

Another argument against truth telling is that patients do not want to be given bad news or serious risks. Although there are individuals who do prefer to leave the decision up to the doctor this does not justify a global policy of lying or deception. Most studies suggest that patients generally want more information and not less. In one study the doctor

underestimated the patient's desire for information in 65% of the encounters (Waitzkin (1984)). Withholding information or lying is the type of behaviour characteristic of a relationship in which the physician retains a high degree of control over the encounter and is paternalistic in nature.

Ellin (1991) distinguishes between lying and deception. Lying is the provision of false information while deception is the provision of true information that in some way fails to convey the whole picture. This may be achieved through a combination of withholding some information and providing other information that appears to be sufficient. It is the politician's art. Ellin argues that there should be an absolute prohibition on lying but deception should not even be considered a *prima facie* wrong. He suggests that deception should just be another medical tool, which is justified providing it is used in the patient's best interests. This model places beneficence above autonomy. The difficulty with it is that the doctor will have to make a judgment about the patient's best interests when that role is really the prerogative of the autonomous patient. It is arguably over paternalistic.

One final problem with the practice of lying and deceiving is that, although purported to be in the patient's best interests, it may simply be a result of or a defence to an inability to communicate effectively in a sensitive and compassionate way. Randall and Downie (1996) argue: 'The high value which we place on truth in the community, in conjunction with our concept of individuality and of ownership of our bodies, leads to the conclusion that we are entitled to the truth about our health which intimately relates to our welfare.' As Sissela Bok (1978) notes: '…we are coming to learn much more about the benefits [information] an bring patients. People follow instructions more carefully if they know what their disease is and why they are asked to take medication… Similarly, people recover faster from surgery and tolerate pain with less medication if they understand what ails them and what can be done for them.'

Think point

Is lying to a patient ever justified?

1.3 Paternalism

Buchanan (1978) defines paternalism as 'interference with a person's freedom of action or freedom of information, or the deliberate dissemination of misinformation, where the alleged justification of interfering or misinforming is that it is for the good of the person who is interfered with or misinformed'.

Gerald Dworkin (1972) provides a simpler, but less broad definition: '[Paternalism is] the interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests or values of the person being coerced.'

Mappes and Zembatty (1991) state: 'Paternalism is the interference with, limitation of, or usurpation of individual autonomy justified by reasons referring exclusively to the welfare or need of the person whose autonomy is being interfered with, limited, or usurped.'

A simple conception of paternalism is to view it as treating another person as a child. It is perhaps preferable to adopt a point in between Dworkin's and Mappes and Zembatty's definition. Thus, paternalism is:

> …the interference with a person's liberty (in any sense of the word) justified as being in the 'best interests' of that person.

JS Mill argued that the only justification for interfering with another person's liberty is to prevent harm to others. He tempered this strong stance against paternalism by arguing that it did not apply to children or the mentally incompetent.

There are three reasons why paternalism is generally unjustified:

(1) The idea that doctor knows best is unfounded. It falters because the doctor is unlikely to know enough about the individual patient to enable him to make such a judgment.
(2) Very often, in making such a best interests judgment the healthcare professional is simply substituting their own moral values for those of the patient. There is no reason to think that the healthcare professional has any expertise, qualification or right to believe that their moral values are preferable to the patient's.
(3) Paternalism infringes the right of the individual to control what happens to them. It fails to respect the person, his personality, individuality and autonomy.

Paternalism is, however, occasionally justified. 'Weak paternalism' is consistent with JS Mill's position. It holds that paternalism is justified:

(1) to prevent those with a significantly reduced autonomy from harming themselves;
(2) to temporarily restrain a person from an apparently irrational self-harming act while it is determined whether that person has sufficient autonomy. This justifies the non-consensual treatment of persons who have attempted to commit suicide until their competency can be formally assessed.

1.4 Virtues

A moral approach that can be used as an alternative, or supplement, to the principles approach is to focus on self-development and the characteristics that a moral person should strive to enhance. These characteristics are called 'virtues'. Both Kant and Mill support the idea of personal development. As Mill (1991) puts it: 'In proportion to the development of his individuality, each person becomes more valuable to himself, and is therefore capable of being more valuable to others.' Randall and Downie (1996) suggest that healthcare professionals have a duty to maintain their own self-development because it ensures the professional is a 'morally developed person who happens to follow a given professional path… [which]…is good both for its own sake and for what it gives to patients, friends, and families'.

Virtues that are particularly valuable in a healthcare setting include:

- compassion (caring);
- kindness;
- forgiveness;
- generosity;
- integrity;
- humility;
- courage;
- fidelity;
- trust;
- justice or fairness;
- understanding.

1.5 Power

A number of writers focus on issues of power. There is a disparity in power between the healthcare professional and the patient. In most settings the healthcare professional enjoys the balance of power because:

- he has a greater knowledge of health matters;
- the interview is usually on his home ground (where the patient is seen on a home visit the power balance shifts);
- his autonomy is unaffected by illness, disease or the need for someone else's help;
- the language, discourse and institution of medicine all favour the healthcare professional;

- he has 'control' over what treatments to offer, the timing of the treatments and the place of the treatments.

Howard Brody (1992) argues that the physician's power can be divided into three components:

(1) Aesculapian: derives from the medical skills and knowledge he possesses.
(2) Charismatic: derives from the physician's personal qualities.
(3) Social: derives from the social standing of physicians.

Brody argues that: The central ethical problem in medicine is the responsible use of power.' For this, the physician must 'own' (acknowledge), 'share' (with the patient) and 'aim' (direct its use for the benefit of the patient) that power.

A post-modern approach decries the rational principles approach that focuses on ethical dilemmas in retrospect at the professional-patient level. Instead, the principles should be applied within an approach that 'includes issues of discourse, power, control and subjectivity' (McGrath (1998)). This involves applying the principles, such as autonomy, within an institution whose discourse provides a way of approaching autonomy that empowers the patient, offers them real choices, enables them to make a choice and supports that choice in a non-judgmental manner. A failure to take a global view of the situation risks the possibility that the application of the principles will simply promote the current biomedical discourse and further the physician-patient power imbalance.

1.6 Models of professional-patient relationships

Various models (see Veatch (1972)) have been described to try and explain the ideal relationship that should exist between healthcare professional and patient. None of the models are perfect as the relationship probably varies depending on the context. The reality is more complex than can be defined by a single model and a combination of these models is necessary. However, the models may be useful in defined circumstances.

1.6.1 The fiduciary or trustee model

In this model the patient places is body and his health 'in trust' with the physician. The physician is morally obligated to act in that patient's best interests. The physician must consider the wishes of the patient but ultimately it is he who must take responsibility for the decision. While there are elements of this model in all professional-patient relationships, it is perhaps best suited to the medical care of an incompetent patient. It also

applies where the patient requests that the physician (assuming he accepts the responsibility) make the decision for him.

1.6.2 The priestly model

This represents the traditional paternalistic doctor-patient relationship. Its main ethical principle is 'benefit and do no harm to the patient'. It is a paternalistic model that ascribes a religious or spiritual authority to the doctor and creates an unbalanced ethical situation that devalues individual freedom and dignity, truth telling, promise keeping and justice. It enhances the doctor's power at the expense of the patient and tends to focus on the patient's medical needs to the exclusion of everything else.

1.6.3 The engineering model

This results from the impact of science. The doctor behaves like an applied scientist and vainly attempts to divorce himself from all value judgments. The physician presents all the facts to the patient and leaves the entire responsibility of making the decision to the patient. Veatch (1972) suggests, this 'would make him an engineer, a plumber making repairs, connecting tubes and flushing out clogged systems, with no questions asked'.

1.6.4 The customer-salesperson model

In this model the patient takes the role of the customer. The essential feature of this model is that 'the customer is always right'. The duty of care of the physician is simply to respond honestly to any requests for information but he is under no obligation to volunteer the information. The physician is under a duty to only provide 'goods' that are suitable for their purpose and must also warn of any dangers or risks. Ultimately, however, sole responsibility lies with the patient and the physician accepts no moral responsibility for the treatment decision. This model gains credibility from the political drive to run healthcare along the lines of a market economy. However it reduces the role, duty and moral responsibility of the physician too far. It also means that a healthcare professional may sometimes have to provide a service that they are morally opposed to (see Randall and Downie (1996)).

1.6.5 The collegial or partnership model

The physician and patient are colleagues working in partnership towards the common goal of restoring and maintaining the patient's health. It enhances the roles of trust, confidence and commitment creating an 'equality of dignity and respect' (Veatch (1972)). Both parties share the responsibility for decision making. This model is wholly inappropriate when the patient lacks sufficient

autonomy. It also fails to recognise the reality that the doctor usually has a far greater knowledge than the patient. Furthermore the doctor's autonomy is not diminished by ill health and the interaction is usually on the doctor's home ground. All these factors result in a power imbalance that makes a truly equal partnership difficult to achieve. It is perhaps also unrealistic, because of ethnic, class, religious, economic and value differences, to expect doctors and their patients to share common goals.

1.6.6 The contractual model

This is to be seen as a symbolic contract or covenant, which provides expected obligations and benefits for both parties arrived at through negotiation. It recognises that their may not be common goals and it respects the 'basic norms of freedom, dignity, truth-telling, promise-keeping and justice' (Veatch (1972)). It requires the trust and confidence of both parties and respects the autonomy and moral values of both doctor and patient. It means that a doctor is not obliged to provide a treatment they disagree with and it means that a patient cannot be treated against their will. The patient accepts moral responsibility for his decision while the doctor retains responsibility for the choices offered to the patient, assistance given to help the patient understand and make their decision, and in the performance of the treatment agreed upon. Again, it is an inappropriate model for incompetent patients. Also, since the provision of the goods is in the hands of the doctor, there may be an undue imbalance of power. This is especially true in a healthcare setting where the patient does not directly pay for the doctor's services. Theoretically, the patient can shop around for a doctor willing to provide the required service but this is not often practical in a system that operates through regional funding. It may also be impossible if the patient is seriously ill. As Randall and Downie (1996) note: 'It tells you how you must not act but not how you should act.' Thus, a contractual model may not always enable a consensual decision that is in the best interests of the patient as a holistic person.

Note

Feminist philosophers have criticised this individualistic approach to medical relationships as failing to take into account the effect of prevailing social and cultural conditions. It views the doctor-patient relationship from the perspective of an educated white middle class male. The autonomy of less privileged individuals may preclude such a relationship. Instead we should view these interactions in context: taking notice of the power imbalance created by the patient's race, sex, social class, etc. Apart from the fact that these individuals

may require a more positive approach to ensure they are enabled to make an autonomous choice the entire social institution of medicine—including the patriarchal training of doctors—needs to be reconsidered within a social and cultural context (see Parks (1998)).

1.6.7 The educational model

The educational model was proposed to account for healthcare provision by teams of professionals and to allow consideration of patients whose previous lives have been so radically altered by disease or injury that they need time to adjust. The model allows a greater leeway for paternalism in the early stages of an encounter while the patient is 're-educated' to understand the potentials and limitations that their new condition has placed on their prior autonomy. The process should always aim to enhance the patient's autonomy. Caplan states: 'In the earliest stages of care which follow the onset of unexpected, irreversible, and severe impairment, the healthcare team has an obligation to act in ways that encourage patients to participate in their own care, not simply to present options.' The aim is to gradually increase the patient's involvement in making decisions for themselves about the rehabilitation programme. It thus requires regular assessment and review. The model also encourages the involvement of the patient's relatives and agreement with the patient should be sought as to the extent of his family's involvement. The patient should also be made aware of the team approach and where the power and responsibility lie within the team. Caplan stresses that the model does not justify non-consensual invasive interventions (see Caplan (1988)).

1.7 The goals of medicine

1.7.1 Traditional goals

- The saving and extending of life.
- The promotion and maintenance of health.
- The relief of pain and suffering.

1.7.2 Definition of health

…the experience of well being and integrity of mind and body…characterized by an acceptable absence of significant malady, and consequently by a person's ability to pursue his or her vital goals and to function in ordinary social and work contexts [Callahan (1996)].

1.7.3 Four goals of medicine

- The prevention of disease and injury and the promotion and maintenance of health.
- The relief of pain and suffering caused by maladies.
- The care and cure of those with a malady, and the care of those who cannot be cured.
- The avoidance of premature death and the pursuit of a peaceful death.

Note

A premature death is one that occurs before the person 'had an opportunity to experience the main possibilities of a characteristically human life cycle… Within an individual life cycle a death may be premature if, even at an advanced age, life could be preserved or extended with no great burden on the individual or society' (Callahan (1996)).

1.7.4 The BMA's primary goal of medicine

… to benefit the patient by restoring or maintaining the patient's health as far as possible, maximising benefit and minimising harm. If treatment fails, or ceases, to give a net benefit to the patient (or if the patient has competently refused the treatment) the goal cannot be realised and the justification for providing the treatment removed…[BMA (1999)].

Think point

If the doctor's personal moral values conflict with the patient's choice, then should the doctor put aside his own beliefs and treat the patient as requested?

2 Consent and Information Disclosure

The moral basis of consent is founded on the principle of autonomy. In the US case, *Schloendorff v Society of New York Hospital* (1914), Cardozo J famously stated, 'every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault'.

Consent transforms a morally forbidden act into a morally permitted act and this transformation is recognised and given legal force in both criminal law (for example, rape and battery) and in the civil law of trespass against the person. Thus, in the Court of Appeal hearing of *Re F (Mental Patient: Sterilisation)* (1990), Neill LJ stated: Treatment or surgery which would otherwise be unlawful as a trespass is made lawful by the consent of the patient.'

Generally there are three conditions that must be satisfied for consent to be legally effective: (1) the patient must be competent to make the decision; (2) the patient must understand the nature and purpose of the act; and (3) the decision must be voluntary (free from coercion, undue influence). A further constraint is that the act is one that is not contrary to public policy or made unlawful by statute (see later).

2.1 The patient must be competent to give consent

2.1.1 There is a presumption of competence in favour of the patient

Re T (Adult: Refusal of Medical Treatment) (1992) CA

For the facts and decision, see 2.3.1.

Lord Donaldson MR stated:

> The right to decide one's own fate presupposes a capacity to do so. Every adult is presumed to have that capacity but it is a presumption that can be rebutted. This is not a question of the degree of intelligence or education of the adult concerned.

2.1.2 Even where the patient is suffering from a mental disorder or disability there is a presumption of competence

Re C (Adult: Refusal of Treatment) (1994)

C was an elderly chronic schizophrenic who had been resident in Broadmoor for 30 years. He had developed a gangrenous foot. The risk of his death without amputation was estimated to be about 85%. C refused consent because he was born with four limbs and he intended to die with them intact. He also believed that God did not want him to have an amputation. One of his delusional beliefs was that he was a great doctor with the ability to cure damaged limbs and had never failed to cure his patients. He did accept that without the amputation he might die.

Held: in granting an injunction to prevent amputation, Thorpe J held that there was a rebuttable presumption in favour of C's competence.

Note

The Law Commission (1995) proposed 'a person should not be regarded as unable to make a decision by reason of mental disability merely because he or she makes a decision which would not be made by a person of ordinary prudence'.

2.1.3 An irrational decision may be evidence of incompetence but it is not the same as incompetence

Re MB (Medical Treatment) (1997) CA

MB was a 23 year old pregnant woman, who first sought antenatal care at 33 weeks. A caesarean section was advised because the baby was in a breech position. She consented to the caesarean operation but, because of a needle phobia, refused consent to the anaesthesia. Initially she agreed to inhalational anaesthesia via a mask but then withdrew that consent when she saw the mask. The risk to her baby was assessed as a 50% risk of serious injury if delivered vaginally. There was, however, little physical risk to the mother. The hospital sought a declaration that it would be lawful to operate. At first instance, Hollis J granted the declaration on the basis that the needle phobia rendered MB temporarily incompetent to decide.

Held: appeal dismissed. Because her needle phobia rendered her incompetent, the declaration that a non-consensual caesarean section was lawful was upheld.

Butler-Sloss LJ said:

A competent woman who has the capacity to decide may, for religious reasons, other reasons, rational or irrational reasons or for no reason at all, choose not to have medical intervention even though the consequence may be the death or serious handicap of the child she bears or her own death.

An irrational decision is 'a decision which is so outrageous in its defiance of logic or accepted moral standards that no sensible person who had applied his mind to the question to be decided could have arrived at it'.

Note

The ideal is that the test should be applied to the patient's *capacity* to make decisions rather than the actual decision. This has to be the case if Butler-Sloss LJ's *dictum* is followed. However, in many cases, including *Re C,* the test seems to be applied to the patient's actual decision (see, also, *Rochdale Healthcare (NHS) Trust v C* (1997)).

2.1.4 The threshold for competence varies with the seriousness or risk of the decision

Re T (Adult: Refusal of Medical Treatment) (1992) CA

For the facts, see 2.3.1.

Lord Donaldson MR stated:

What matters is that doctors should consider whether at that time he had a capacity which was commensurate with the gravity of the decision which he purported to make. The more serious the decision, the greater the capacity required.

Note

This risk-related standard is open to the criticism that the level of competence required varies with the complexity of the decision rather than its gravity. Certainly it does not always seem to be applied. It was not referred to in *Re C (Adult: Refusal of Treatment)* and appears not to have been applied in that instance. It was, however, referred to with approval in *Re MB (Medical Treatment)*.

2.2 The patient must understand the nature and purpose of the act

2.2.1 The consent must be for the procedure performed

Mohr v Williams (1905) USA

The plaintiff consented to an operation on her right ear. During the operation, while the plaintiff was anaesthetised, the surgeon found that it was the left ear rather than the right ear that required surgery. He successfully performed the operation on the plaintiff's left ear.

Held: the surgeon was liable for battery.

The judgment stated:

> If a physician advises a patient to submit to a particular operation, and the patient weighs the dangers and risks incident to its performance, and finally consents, the patient thereby, in effect, enters into a contract authorizing the physician to operate to the extent of the consent, but no further.

See, also, *Cull v Butler* (1932), in which a surgeon was liable for battery when he removed the plaintiff's uterus (womb) even though she had only consented to an abortion.

2.2.2 If the operation performed is not the one for which consent has been given then it is irrelevant that it was in the patient's best interests

Devi v West Midlands RHA (1981) CA

The patient consented to an operation to repair her ruptured uterus, which had been punctured during an evacuation of retained products following the birth of her fourth child. Because he believed it was in her best interests, the surgeon, while her abdomen was open anyway, sterilised her by occluding her fallopian tubes.

Held: the surgeon was liable for battery.

2.2.3 Providing the patient has given a 'real' consent then there will be no liability for battery

Chatterton v Gerson (1981)

The plaintiff suffered chronic pain in a scar from a previous hernia operation. The defendant administered spinal phenol to destroy the appropriate pain conducting nerves. Following the second injection, the plaintiff's right leg was left numb and her mobility was affected. She

alleged that her consent was invalid because she had not been warned of these risks.

Held: the plaintiff's action for trespass failed.
Bristow J stated:

> It is clear that in any context in which the consent of the injured party is a defence to what would otherwise be a crime or a 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.

Note

This case established the current conditions for determining whether a lack of information invalidates consent and gives rise to battery or whether the more appropriate cause of action is in the tort of negligence. Thus, 'the cause of action on which to base a claim for failure to go into risks and implications is negligence, not trespass', *per* Bristow J. In the event, the plaintiff's claim for negligence also failed.

2.2.4 It is not necessary for 'real' consent that the risks associated with a procedure be disclosed

Hills v Potter (1984)

The plaintiff was operated on to relieve the spasmodic torticollis affecting her neck. Following the operation the patient was left paralysed. The plaintiff alleged that, because of the defendant's failure to inform of the risks, her consent to the operation was not 'real or effective' and the operation was a battery.

Held: the plaintiff's consent was 'real' and the operation was not a battery. The plaintiff's claim in negligence also failed.

Hirst J stated:

> I should add that I respectfully agree with Bristow J *[Chatterton v Gerson]* in deploring reliance on these torts in medical cases of these kind; the proper cause of action, if any, is negligence.

See, also, the quote from Bristow J in *Chatterton* (above) and the judgment of Laskin CJC in the Supreme Court of Canada hearing of *Reibl v Hughes* (1981), in which he stated:

> I can appreciate the temptation to say that the genuineness of consent to medical treatment depends on proper disclosure of the risks which it entails, but in my view, unless there has been misrepresentation or fraud to secure consent to the treatment, a failure to disclose the attendant risks, however serious, should go to negligence rather than battery.

Note

Hirst J's comment shows how reluctant the courts are to find a doctor liable for battery. Hence the sometimes strained reasoning that can be found (see *Davis v Barking, Havering and Brentwood HA,* below).

2.2.5 If the nature and effect of a procedure has been explained in broad terms, it is not necessary to get a separate consent for each part of that procedure

Davis v Barking, Havering and Brentwood HA (1993)

The plaintiff underwent a minor gynaecological procedure. She signed a general consent form which stated: 'I also consent…to the administration of general, local or other anaesthetics for any of these purposes.' She was given a general anaesthetic and while asleep the anaesthetist performed a caudal local anaesthetic block. She was left with loss of sensation in her left leg and altered bladder control. The plaintiff claimed damages for battery because she had not specifically consented to the caudal.

Held: it was enough that the patient understood, in broad terms, that she would have an anaesthetic. The explanation of the general anaesthetic satisfied that requirement. It was not necessary to 'sectionalise' consent to include a separate consent for every possible form of anaesthesia.

McCullough J stated:

> Each case must depend on its own facts. Whether a particular aspect of what is proposed is a matter of detail or is in reality a matter sufficiently separate to call for separate mention is a question of fact and degree.

Note

McCullough J's approach strains the concept of 'real' consent to breaking point and clearly originates from a judicial desire not to find doctors liable for battery. The General Medical Council (GMC) has adopted a different, and arguably more appropriate, approach. They held an anaesthetist was guilty of serious professional misconduct when—although the patient had consented to the general anaesthetic—he failed to get specific consent for a rectally administered pain killer that he inserted while she was still asleep.

Think point

If a patient consents to a catheterisation of his heart for diagnostic purposes would the doctor be liable for battery if he uses a catheter for therapeutic purposes?

2.2.6 In determining what is included in a patient's consent, it is necessary to look at all the circumstances leading up to the signing of the consent form

Brusnett v Cowan (1991) Newfoundland CA

The plaintiff consented to a diagnostic muscle biopsy. She signed a consent form that stated she agreed to any 'further or alternative measures as may be found to be necessary during the course of the operation'. The defendant performed the muscle biopsy but also biopsied the underlying bone. The plaintiff alleged that she had not consented to the bone biopsy and sued for damages in battery.

Held: looking at the whole set of circumstances, she had not consented to just a muscle biopsy. Her consent was more properly seen as to an investigative procedure for the problem she was having in her right leg. This included, in such broad terms, both the muscle and bone biopsy.

2.2.7 It is the content, not the form, of a consent that is important

A pre-printed consent form signed by the patient is evidential only. It is not a substitute for 'real' consent but may provide evidence to support a claim that consent was in fact obtained.

Chatterton v Gerson (1981)

For the facts, see 2.2.3.

Bristow J stated, *obiter,* that:

> …getting the patient to sign a *pro forma* expressing consent to undergo the operation 'the effect and nature of which have been explained to me'…should be a valuable reminder to everyone of the need for explanation and consent. But it would be no defence to an action based on trespass to the person if no explanation had in fact been given. The consent would have been expressed in form only, not in reality.

Note

It is common for consent forms to contain clauses that indicate that the patient agrees to whatever further procedures may be necessary (or understands that such procedures will only be carried out if necessary in the patient's best interests). On the face of it, this should only allow procedures which are essential to preserve life and cannot wait. But, in *Pridham v Nash* (1986), Holland J argued that such clauses allowed the surgeon to therapeutically divide adhesions (unfortunately resulting in peritonitis) during a diagnostic laparoscopy. Holland I limited the clause to minor surgery: 'If the laparoscopic examination, an investigative procedure, had revealed a major problem requiring

surgery then, in my view, the surgeon would not be entitled to rely on the original consent and the general words of the consent…to carry out the major surgery.'

2.2.8 It is for the patient to prove an absence of consent

Freeman v Home Office (No 2) (1984) CA

The plaintiff was serving a term of life imprisonment. He alleged that drugs had been forcibly administered to him without his consent. The plaintiff claimed that, because he was a prisoner, he was not capable of consenting.

Held: appeal denied. He was capable of consenting and had failed to establish that he had not in fact done so.

Note

In the High Court, McCowan J considered Bristow J's judgment in *Chatterton v Gerson*. He stated: 'I would read this as indicating that Bristow J took the view that it was for the plaintiff to show the absence of real consent.' The Court of Appeal did not refer to the point but it is consistent with the law relating to rape from which the courts have carried over the principles relating to mistake, fraud and misrepresentation. It is also consistent with the criminal law of assault: see *Attorney General's Reference (No 6 of 1980)* (1981), where Lord Lane CJ stated: 'We think that it can be taken as a starting point that it is an essential element of an assault that the act is done contrary to the will and without the consent of the victim; and it is doubtless for this reason that the burden lies on the prosecution to negative consent.'

Note

The opposite is true in Australia where the burden of proof lies with the doctor: see *Department of Health & Community Services (NT) v JWB and SMB* (1992).

2.3 The patient's consent must be voluntary

2.3.1 Consent may be vitiated by duress

Re T (Adult: Refusal of Medical Treatment) (1992) CA

T, a pregnant woman, was admitted to hospital following a car accident. T herself was not a Jehovah's Witness but, following a private

conversation with her mother—who had raised T and was a practising Jehovah's Witness—refused any blood transfusions. When an emergency caesarean section became necessary, she repeated her refusal. After the operation, her condition worsened and she was kept sedated and ventilated in the intensive care unit. Her father and boyfriend appealed to the court to authorise a blood transfusion despite her earlier refusal of consent. At first instance, the judge held that T had neither consented or refused consent and it would be lawful under the doctrine of necessity for the doctors to administer blood. T appealed.

Held: appeal dismissed. It was lawful for the doctors to administer the transfusion. The evidence showed that T's medical condition rendered her unfit to make a genuine decision and her mother had subjected her to an 'undue influence' which vitiated her decision to refuse the blood.

Staughton LJ stated:

> In order for an apparent consent or refusal of consent to be less than a true consent or refusal, there must be such a degree of external influence as to persuade the patient to depart from her own wishes, to the extent that the law regards it as undue.

Freeman v Home Office (1984) CA

The plaintiff was serving a term of life imprisonment. He alleged that a prison medical officer, with other prison officers, had administered drugs to him by force against his consent. He argued: (i) that the prescribed drugs were used to control him rather than treat any recognised mental disorder; (ii) that a prisoner could not, in law, give consent to treatment by a prison medical of7ficer where the medical officer was acting as a disciplinarian rather than doctor; and (iii) that he had not been adequately informed of the reason for treatment, the precise nature of the treatment or the risks of treatment, and without that information his consent was not legally valid.

Held: appeal dismissed. The Court of Appeal rejected the plaintiff's submission that a prisoner was incapable of giving a free and voluntary consent. They further held that the doctrine of informed consent (see later) was not part of English law and a prisoner was capable of giving consent to a prison medical officer.

Sir John Donaldson MR stated:

> Consent would not be real if procured by fraud or misrepresentation but, subject to the patient having been informed in broad terms to the nature of the treatment, consent in fact amounts to consent in law.

The Court of Appeal accepted the trial judge's statement ([1983] 3 All ER 589):

The right approach, in my judgment, is to say that where, in a prison setting, a doctor has the power to influence a prisoner's situation and prospects a court must be alive to the risk that what may appear, on the face of it, to be a real consent is not in fact so.

Think point

What would be the ethical and legal position where a prisoner's consent to experimental treatment as part of a clinical trial is obtained by offering the prisoner extra privileges or earlier parole? Would the situation be any different if it involved asking the prisoner to donate bone marrow or a kidney?

2.3.2 Consent may be vitiated by mistake either as to the nature of the act or as to the identity of the actor

Fraud or misrepresentation may induce the mistake but neither is necessary. In *Papadimitropolous v R* (1957), the High Court of Australia stated: In considering whether an apparent consent is unreal it is the mistake or misapprehension that makes it so. It is not the fraud producing the mistake which is material so much as the mistake itself.'

Appleton v Garrett (1997)

The plaintiffs had expensive restorative dental work carried out on healthy teeth. The work was unnecessary and the defendant dentist had carried it out purely for financial gain.

Held: none of the plaintiffs had given a 'real' consent and the treatment was a battery.

R v Richardson (1998) CA

The appellant was a dentist who had been suspended from practising. Despite the suspension she continued to treat her patients. She was charged with assault occasioning actual bodily harm. The trial judge ruled that her patient's apparent consent was vitiated by her fraud in allowing her patients to think she was still registered. Because of this ruling she changed her plea to guilty. She appealed on the grounds that the judge's ruling was incorrect.

Held: appeal allowed. Only a mistake about the nature of the act alleged to or the identity of the assailant vitiated consent in criminal law. A person's professional status or qualifications did not constitute part of their identity.

Note

Otton LJ suggested that her actions were 'clearly reprehensible and may well found the basis of a civil claim for damages. But we are quite satisfied that it is not the basis for finding criminal liability in the field of offences against the person'. It is unlikely that any claim for damages in trespass would be successful. In the Court of Appeal hearing of *Sidaway v Governors of Bethlem Royal Hospital* (1984), Donaldson MR stated: 'It is only if the consent is obtained by fraud or misrepresentation of the nature of what is to be done that it can be said that an apparent consent is not a true consent. This is the position in the criminal law and the cause of action based on trespass to the person is closely analogous.'

R v Tabassum (2000) CA

Three women consented to be shown how to perform a breast examination by the accused who was preparing a computer software package on breast cancer. They knew that the act was a breast examination and that it was for the purpose of preparing the software package The women all stated that they only consented to the examination because they believed the accused was medically qualified or properly trained. It was accepted that neither of these was the case. He was convicted of indecent assault and appealed.

Held: appeal dismissed. The women had not given a true consent. Because he was not medically qualified nor properly trained, the quality of the act could not have been one of a medical examination. Thus, although the women understood the nature of the act, they had not consented to the quality of the act.

Note

Richardson was distinguished because it related to the identity of the actor rather than the quality of the act. This decision would be incompatible with *Richardson* but for this distinction. Although the decision gives a greater protection to autonomy, it may be criticised as being achieved through judicial sleight of hand and legal sophistry. It is arguable that the judges were not sympathetic to the appellant solely because he was not medically qualified and that the manner in which they have extricated themselves from the *Richardson* decision merely confirms the judicial reluctance to find medically qualified professionals criminally liable. It also has the undesirable implication that success or failure could depend on whether the case is based on the 'identity of the actor' rather than the 'quality of the act'.

R v Bolduc and Bird (1976) Supreme Court of Canada

A woman consented to a vaginal examination in the presence of a curious layman whom her doctor had misrepresented as a medical intern seeking experience.

Held: appeal allowed and convictions quashed. The fraud did not relate to the 'nature and quality' of the act but to the observer's identity which was collateral to the act.

Think point

Spence J dissented from the main judgment. He argued that the act consented to was 'vaginal examination in the presence of a doctor' and not 'vaginal examination in the presence of a layman'. Which judgment (main or dissenting) do you think was (a) legally (b) morally correct?

2.4 A doctor owes a duty of care to provide his patient with sufficient information to enable his patient to decide whether to give their consent to the proposed treatment

Per Lord Scarman in *Sidaway* (below):

> I conclude, therefore, that there is room in our law for a legal duty to warn a patient of the risks inherent in the treatment proposed, and that, if such a duty be held to exist, its proper place is as an aspect of the duty of care owed by the doctor to his patient.

Think point

If the moral basis of consent is a respect for the individual's autonomy then should the appropriate standard of care be doctor-centred or patient-centred?

2.4.1 The standard of care required for information disclosure is measured by the *Bolam* test (see Chapter 12)

Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital (1985) HL

The plaintiff had an operation to relieve her recurrent neck and shoulder pain. The operation carried a risk of damage to a nerve root of 1–2%. There was also a substantially smaller risk to her spinal cord. She was informed of the risk to the nerve root but the surgeon did not refer to the risk of paralysis

that might result from damage to her spinal cord. The operation was performed competently but, unfortunately, the risk to her spinal cord materialised and she was left severely disabled. The plaintiff sued the surgeon for failing to inform of this risk.

Held: the surgeon was not liable since he had followed a practice which, at that time, was accepted as proper by a responsible body of skilled and experienced neurosurgeons.

Note

The Lords failed to agree on the appropriate standard. Lord Scarman dissented from the majority that the *Bolam* test was applicable. He preferred the 'prudent patient' test established by the US case *Canterbury v Spence* (1972). He stated: 'I think that English law must recognise a duty of the doctor to warn his patient of risk inherent in the treatment… The critical limitation is that the duty is confined to material risk. 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.' Lord Diplock preferred the *Bolam* test without qualification. The other Lords agreed that *Bolam* was the appropriate standard but that this standard was subject to judicial scrutiny and approval. Lord Bridge stated: '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.'

2.4.2 *Bolam* applies to information disclosure in both therapeutic and non-therapeutic contexts

Gold v Haringey HA (1988) CA

Following the birth of her third child the plaintiff underwent an operation to sterilise her. Following the operation she became pregnant. She sued the Health Authority in negligence for, *inter alia*, failing to warn her of the failure rate of female sterilisations. If she had known of the failure rate her husband would have had a vasectomy instead. At first instance the judge held that the *Bolam* test only applied to therapeutic procedures and, on the evidence, the defendants had been negligent.

Held: appeal allowed. As far as the doctor's duty of care went, there should be no distinction made between advice given in a therapeutic context and advice given in a non-therapeutic context. The *Bolam* test was applicable in both instances.

Per Lloyd LJ:

> The *[Bolam]* principle does not depend on the context in which any act is performed, or any advice given. It depends on a man professing skill or competence in a field beyond that possessed by the man on the Clapham omnibus.

Note

The Court of Appeal considered the judgment in *Sidaway*, but only referred to Lord Diplock's speech. They have apparently interpreted the mixed judgment in *Sidaway* as affirming the application of an unmodified *Bolam* test.

Think point

If there is no distinction between therapeutic and non-therapeutic treatment, should the courts adopt a similar approach to information disclosure in the context of a volunteer agreeing to participate in clinical trial?

2.4.3 Risks that are not material to the procedure need not be disclosed

Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital (1985) HL

For the facts, see 2.4.1.

Lord Scarman stated:

> The two critically important medical factors are the degree of probability of the risk materialising and the seriousness of the possible injury, if it does… Another medical factor…is the character of the risk…is the risk common to all surgery…or is it specific to the particular operation under consideration… the court may well take the view that a reasonable person in the patient's situation would be unlikely to attach significance to the general risks: but it is not difficult to foresee circumstances particular to a patient in which even the general risks of surgery should be subject to warning by his doctor: for example, a heart or lung or blood condition. *Special risks inherent in a recommended operational procedure are more likely to be material* [author's emphasis].

Note

In *Rogers v Whitaker* (1993), the High Court of Australia rejected *Bolam* as an inappropriate standard for risk disclosure. The majority opted for a 'prudent patient' standard and stated, 'the risk was material, in the sense that a reasonable person in the patient's position would be likely to attach significance to the risk and thus

require a warning'. This view, however, has not been adopted in this country.

2.4.4 Material risks do not include 'ordinary', 'general' or 'obvious' risks

White v Turner (1981) Canada

The defendant performed breast reduction surgery on the plaintiff, which left her breasts misshapen and badly scarred. She alleged that the performance of the operation was negligent and that the defendant was negligent in not properly disclosing the risks of the surgery.

Held: in this case the risk of asymmetrical nipples, misshapen breasts and scars that might stretch to a width of two to three inches were material risks. The defendant was negligent in not warning the plaintiff of these risks.

Per Linden J:

> There are some common everyday risks that exist in all surgery, which everyone is expected to know about. Doctors need not warn about them, since they are obvious to everyone. Consequently, just as one need not warn that a match will burn or that a knife will cut, because that would be redundant, one need not warn that, if an incision is made, there will normally be some bleeding, some pain and a scar.

Venner v North East Essex HA (1987)

A woman who had been taking oral contraceptives for many years decided—after her third child—that she should be sterilised. The defendant advised her to stop taking the pill about a month before the operation so as to reduce the risk of venous thrombosis. In the past, every time she stopped taking the pill she became pregnant. It was no different on this occasion. She sued the defendant on the grounds that he should have warned her that she might become pregnant if she continued to have sex while not taking the pill.

Held: the defendants had not been negligent.

Per Tucker J:

> …it must have been obvious to the plaintiff that while she continued to take the pill she would not conceive but that she would be almost certain to do so if she ceased to take the pill and continued to have sexual intercourse.

Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital (1985) HL

For the facts, see 2.4.1.

Lord Diplock stated:

> …in addition there are involved risks inherent in any general surgery especially if conducted under anaesthesia…the consequences of these other risks may be minor and evanescent or may be gravely and permanently disabling or even result in death itself. I find it significant that no common law jurisdiction either American or Canadian which has espoused the doctrine of 'informed consent' appears to have suggested that the surgeon was under a duty to warn his patient of such general risks which, rare though they may be, do happen and are real risks.

Note

The concept of 'ordinary risk' may depend on the particular patient. In *Sidaway*, Lord Diplock stated, 'it may be that most patients, though not necessarily all, have vague knowledge that there may be some risk in every form of medical treatment, but it is flying in the face of reality to assume that all patients from the highest to the lowest standard of education or intelligence are aware of the extent and nature of the risks which…are inevitably involved in medical treatment of whatever kind it be but particularly surgical'.

2.4.5 A risk is significant enough to be material if a failure to inform a reasonable patient of that risk would affect her judgment in making the relevant decision

Pearce v United Bristol Healthcare NHS Trust (1999) CA

The plaintiff was two weeks beyond the due date of her sixth child. She asked the consultant obstetrician if she could have a caesarean section or be induced. He explained the risks of those two procedures and advised that she allow her pregnancy to continue. The fetus subsequently perished and she was delivered of a stillborn child. She sued the defendants and alleged that, had she been warned of the risk of stillbirth (0.1–0.2%), she would have insisted on a caesarean section.

Held: for negligence to be established, the failure to disclose the risk must have affected the plaintiff's decision. Although the trial judge had made no finding regarding this issue, the Court of Appeal decided that even if she had been told of the risk, the plaintiff would probably still have followed the consultant's advice and continued with the pregnancy.

Lord Woolf MR stated:

> In a case where it is being alleged that a plaintiff has been deprived of the opportunity to make a proper decision as to what course he or she should take in relation to treatment, it seems to me to be the law…that 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.

Note

The Court of Appeal noted with interest that Lord Bridge in *Sidaway* had referred to a significant risk as being greater than 10%. The expert witness commented that, had the risk in this case been over 10%, then it should have been mentioned. Since the risk was *only* 0.1–0.2%, it was not significant. The Court of Appeal has apparently taken the remark out of context. Lord Bridge used the 10% risk as an example of an instance when a doctor could not rely on *Bolam* if he failed to disclose it to the patient. Under such circumstances, the judge could hold that no reasonably prudent doctor would fail to disclose it. Thus, 10% is not the lower limit demarcating significance but is the upper limit demarcating when a judge should no longer accept the medical evidence that non-disclosure was reasonable.

2.4.6 Whether or not the claimant's decision has been affected by the non-disclosure has both a subjective and an objective element

Chatterton v Gerson (1981)

For the facts, see 2.2.3.

Bristow J stated:

> When the claim is based on negligence the plaintiff 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.

This is clearly subjective. However, he then applied the objective test of what a 'lady desperate for pain relief' would have done rather than accepting what the plaintiff claimed she would have done.

Note

This point goes to the issue of causation. If the plaintiff would have made the same decision even if the risk had been disclosed then the failure to disclose could not be said to have caused the damage. Thus, in *Smith v Tunbridge Wells HA* (see 2.4.10), the court held that had a 28 year

old man been told of the risk of impotence he would not have consented to an operation to repair his rectal prolapse. In *White v Turner* (see 2.4.4) the Ontario High Court held: '…it is not enough for the Court to be convinced that the plaintiff would have refused the treatment if fully informed; the court must also be satisfied that a reasonable patient, in the same situation, would have done so.' See, also, *Pridham v Nash* (see 2.2.7), in which Holland J stated: 'Even if I had concluded that Dr Nash should have advised Mrs Pridham of the risk his failure to do so would not have resulted in liability because, applying the objective test, a reasonable person in Mrs Pridham's position would have consented to the surgery.' See Grubb (1998).

2.4.7 The doctor may have a duty to answer truthfully to direct questions

Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital (1985) HL

For the facts, see 2.4.1.

Lord Diplock argued that if the doctor were asked he would 'no doubt …tell him what he wished to know'. Lord Bridge more forcefully argued that 'when questioned specifically by a patient of apparently sound mind about risks involved in a particular treatment proposed, the doctor's duty must, in my opinion, be to answer both truthfully and as fully as the questioner requires'. However, since they were *obiter* to the judgment, although persuasive, they do not decide the point.

2.4.8 Where direct questions are of a general nature the standard of duty that the doctor owes is governed by the *Bolam* test

Blyth v Bloomsbury HA (1993) CA

The plaintiff, a trained nurse, was given an injection of the long-acting contraceptive Depo-provera to prevent pregnancy while waiting for her rubella vaccination to become fully effective. She sued for damages and alleged that she was not warned about some of the side effects she suffered following the injection. She also alleged that the doctor had not answered truthfully to her questions. The trial judge awarded her damages and the defendants appealed.

Held: appeal allowed. On the facts, the Court of Appeal noted that the trial judge did not find that she had asked the specific questions alleged. The Court of Appeal accepted that she had asked general questions but held that the *Bolam* test applied.

Per Kerr LJ:

> The question of what a plaintiff should be told in answer to a general enquiry cannot be divorced from the *Bolam* test any more than when no such enquiry is made. In both cases the answer must depend upon the circumstances, the nature of the enquiry, the nature of the information which is available, its reliability, relevance, the condition of the patient and so forth.

Pearce v United Bristol Healthcare NHS Trust (1999) CA

For the facts, see 2.4.5.

The Court of Appeal held *(obiter)* that if a patient asked about risks the doctor had a duty to give an honest answer.

Note

The law regarding specific questions is not clear. While Lord Bridge in *Sidaway* stated that the doctor must answer 'truthfully and as fully as the questioner requires' (see above), Kerr LJ argued: '…the *Bolam* test is all-pervasive in this context. Indeed I am not convinced that the *Bolam* test is irrelevant even in relation to the question of what answers are properly to be given to specific enquiries, or that Lord Diplock or Lord Bridge intended to hold otherwise.' This is in keeping with an earlier decision in *Hatcher v Black* (1954), in which a doctor replied to a direct question from the patient that a thyroidectomy did not involve any risks. Denning LJ stated: '…[the doctor] told a lie because he thought…it was justifiable…[T]he law does not condemn the doctor when he only does that which many a wise and good doctor would do.'

2.4.9 The doctor may claim 'therapeutic privilege' and withhold information that would cause the patient harm or be contrary to his best interests

Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital (1985)

For the facts, see 2.4.1.

Lord Scarman argued *(obiter)* that in raising therapeutic privilege, the doctor must prove 'that he reasonably believed that the disclosure of the risk would be damaging to his patient or contrary to his best interests'.

Note

In the earlier case, *Hatcher v Black* (see above), it was argued that anxiety increases the risks of thyroidectomy and as such it was justifiable to withhold information from the patient to prevent her becoming more

anxious. The issue of therapeutic privilege was also discussed in the US case of *Canterbury v Spence* (1972), in which the court held that the doctor may withhold information if disclosing it would risk making the patient so distraught that he is incapable of making a decision.

2.4.10 The courts have still reserved the right to decide that, notwithstanding *Bolam*, the body of medical men supporting the defendant's position is not a 'reasonable' body

Newell and Newell v Goldenberg (1995)

The first plaintiff had a vasectomy and following the second of two negative sperm counts was advised that it was safe to have sexual intercourse without contraceptive protection. His wife, the second plaintiff, became pregnant because a natural process (risk of 1:2,300) had restored the first plaintiff's vas deferens. The defendant acknowledged that it was his normal practice to warn of this risk but that in failing to do so, he had still conformed to the practice of a responsible body of medical opinion.

Held: the defendant was negligent in failing to warn of the risk of failure of a vasectomy. The body of medical opinion was neither responsible nor reasonable.

Smith v Tunbridge Wells HA (1994)

The plaintiff, a 28 year old man, underwent an operation to repair a rectal prolapse. Unfortunately, although the surgery was performed competently, a nerve was damaged and the plaintiff was left impotent and with a significant bladder dysfunction. He sued the defendants and alleged that, had he been warned of the risk of impotence, he would not have consented to the operation.

Held: the defendants were negligent. Although some surgeons might not have warned patients in a similar situation to the plaintiff, that omission was neither reasonable nor responsible.

Note

See, also, 12.4.2.

2.4.11 The doctor has a duty to take reasonable steps to ensure the patient understands the information

Smith v Tunbridge Wells HA (1994)

For the facts and decision, see above.

Moorland J stated:

> When recommending a particular type of surgery or treatment, the 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, simple but not misleading, which the doctor 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.

Think point

Should the law insist that the doctor ensures understanding?

2.4.12 The surrounding circumstances may affect the reasonableness of steps to ensure understanding

Smith v Salford HA (1994)

The plaintiff was a window cleaner who suffered pain and restricted movement due to a problem with his neck. The surgeon advised that he should have a cervical fusion operation. The plaintiff suffered temporary tetraplegia and permanent disability preventing him from working. One of the grounds on which he sued was that he had been negligently informed of the risks associated with the surgery.

Held: the doctor had breached his duty by failing to inform the plaintiff the risks of paralysis. However, the plaintiff failed in this aspect of his claim, because even if he had been warned, the plaintiff would have gone through with the operation. (The plaintiff succeeded in establishing the defendant's liability for negligent practice on other grounds.)

Potter J stated:

> I am satisfied no specific mention of death or paralysis was made. Even if I am mistaken, I am satisfied that they were not mentioned in terms adequate to register upon the plaintiff who Mr Cowie [the surgeon] himself acknowledged was, at the time of the interview…suffering a headache and the adverse effects generally of the myelogram which he had recently experienced.

Note

These last two cases suggest that it is not enough simply to make the information available to the patient. The doctor must take reasonable steps to ensure the patient understands the information and this includes providing the information at a time when the patient is likely to be in a suitably receptive state. See, also, *Lybert v Warrington HA* (1996).

2.4.13 The standard of information disclosure expected by the GMC

Patients have a right to information about their condition and the treatment options open to them. The amount of information you give each patient will vary, according to factors such as the nature of the condition, the complexity of the treatment, the risks associated with the treatment or procedure, and the patient's own wishes… When providing information you must do your best to find out about patients' individual needs and priorities. For example, patients' beliefs, culture, occupation or other factors may have a bearing on the information they need in order to reach a decision. You should not make assumptions about patients' views, but discuss these matters with them… You should provide patients with appropriate information, which should include an explanation of any risks to which they may attach particular significance. Ask patients whether they have understood the information and whether they would like more before making a decision. (GMC (1999).)

2.5 Consent to medical research

The question of consent to medical research has not been tested in an English court. However, any research that involves physical contact would certainly require consent to avoid being a battery. Other types of research may—because of the ethical standards required by the professions—be negligent if no consent is obtained. In *Mink v University of Chicago* (1978), the defendants were liable for battery when they administered drugs to over 1,000 women, without telling them that they were part of an experiment, nor that the pills—administered to them during their prenatal care—were Diethyl Stilbestrol. Montgomery (1997), while recognising the dangers of relying on overseas decisions, suggests that English courts may follow the Canadian case *Halushka v University of Saskatchewan* (1965), which held that for consent to medical research to be valid there must be a 'full and frank' disclosure of the facts. It is also possible that the consent requirements for therapeutic research (that is, research that may also provide some clinical benefit to the patient) may only require the *Bolam* standard of information disclosure while non-therapeutic research would require the higher

standard of disclosure. But, see *Gold v Haringey HA* (2.4.2). However, since the *Bolam* test is based on the opinion of a reasonable body of medical opinion, the requirements for information disclosure in medical research will most likely be greater than for medical treatment. This follows because current professional and ethical guidelines demand it.

The Declaration of Helsinki, 1964 (as amended 1996)

Requires:

> …each potential subject must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail.

A revision of the declaration has been proposed which suggests, in addition, that:

> Potential subjects must be made aware of all reasonable alternatives to those procedures or interventions that are performed with the intent and reasonable probability of providing direct health-related benefit to the subjects (World Medical Association, 1999).

The GMC in their handbook, *Seeking Patient's Consent: The Ethical Considerations*, states:

> You must take particular care to be sure that anyone you ask to consider taking part in research is given the fullest possible information, presented in terms and a form they can understand.

2.6 There are some instances where an otherwise real consent may be invalidated

Public policy may invalidate an otherwise valid consent where the act consented to is deemed immoral or not in the public interest: *R v Brown* (1993). Medical treatment generally does not fall within this category. However, female circumcision has been outlawed.

Prohibition of Female Circumcision Act 1985

1 Prohibition of female circumcision

(1) Subject to section 2 below, it shall be an offence for any person—

(a) to excise, infibulate or otherwise mutilate the whole or any part of the labia majora or labia minora or clitoris of another person; or

(b) to aid, abet, counsel or procure the performance by another person of any of those acts on that other person's own body.

2 Saving for necessary surgical operations

(1) Sub-section (1)(a) of section 1 shall not render unlawful the performance of a surgical operation if that operation—

(a) is necessary for the physical or mental health of the person on whom it is performed and is performed by a registered medical practitioner; or

(b) is performed on a person who is in any stage of labour or has just given birth and is so performed for purposes connected with that labour or birth by—

(i) a registered medical practitioner or a registered midwife; or

(ii) a person undergoing a course of training with a view to becoming a registered medical practitioner or a registered midwife.

(2) In determining for the purposes of this section whether an operation is necessary for the mental health of a person, no account shall be taken of the effect on that person of any belief on the part of that or any other person that the operation is required as a matter of custom or ritual.

3 The Incompetent Adult

One of the requirements for consent to be 'real' is that the individual is competent to make the decision in question. If the individual is unable to consent, then they are unable to legitimise medical treatment even if they voluntarily agree to it. Obviously, from an ethical viewpoint it would be iniquitous if the inability to consent (which is, after all, a device meant to protect the individual) prevented the patient from getting medical care. Thus, unless someone else can give consent in place of the individual's consent, some other justification must be found so that incompetent patients can receive any necessary treatment while also protecting the doctor from liability for battery.

3.1 The definition of incompetence

3.1.1 There is a presumption of competence in favour of the patient

Re T (Adult: Refusal of Medical Treatment) (1992) CA

For the facts and decision, see 2.3.1.

Note

The Law Commission (1995) stated: 'We recommend that there should be a presumption against lack of capacity and that any question whether a person lacks capacity should be decided on the balance of probabilities' (Draft Bill, cl 2(6)). This has been accepted by the Government and in the future will be given a statutory footing (Lord Chancellor (1999)).

3.1.2 There are three stages to determining competency

Re C (Adult: Refusal of Treatment) (1994)

For the facts and decision, see 2.1.2.

Thorpe J accepted the three stage suggested by the expert witness Dr Eastman:

(1) Comprehending and retaining treatment information.
(2) Believing it.
(3) Weighing it in the balance to arrive at a choice.

Note

This test was applied in *Re MB* (1997) although the second stage (belief) was omitted.

Think point

What are the main difficulties with this test? Can you think of any alternative tests that might be used to determine competency?

3.1.3 The requirement of 'belief' is not essential

Re MB (Medical Treatment) (1997) CA

For the facts and decision, see 2.1.3.

The Court of Appeal stated:

> A person lacked capacity when some impairment or disturbance of mental functioning rendered that person unable to make a decision. Inability to make a decision occurred when a patient was *unable to comprehend, retain and use information and weigh it in the balance* [emphasis added].

Note

Butler-Sloss LJ based her test on the Law Commission *Report on Mental Incapacity.* The Law Commission recommended that 'legislation should provide that a person is without capacity if at the material time he or she is: (1) unable by reason of mental disability to make a decision on the matter in question, or (2) unable to communicate a decision on that matter…' (Draft Bill, cl 2(1)). A person is unable to make a decision if 'he or she is unable to understand or retain the information relevant to the decision, including information about the reasonably foreseeable consequences of deciding one way or another or failing to make the decision' (Draft Bill, cl 2(2)(a)). The Law Commission also required that the individual 'be able to use the information…in the decision making process'. The Law Commission's proposals will be given a statutory basis by future government legislation (Lord Chancellor (1999)).

3.1.4 A mental disability may be necessary for incompetence but it is not sufficient

Re C (Adult: Refusal of Treatment) (1994)

For the facts and decision, see 2.1.2.

Thorpe J stated:

> Although his [C's] general capacity is impaired by schizophrenia, it has not been established that he does not sufficiently understand the nature, purpose and effect of the treatment he refuses.

3.1.5 The mental disability may be caused by a temporary factor

Re MB (Medical Treatment) (1997) CA

For the facts, see 2.1.3.

Held: MB's needle phobia rendered her temporarily incompetent and a non-consensual caesarean section would be lawful.

The Court of Appeal stated:

> Temporary factors such as shock, pain or drugs might completely erode capacity but those concerned had to be satisfied that such factors were operating to such a degree that the ability to decide was absent.

3.1.6 Being in labour may be a sufficient cause of temporary incapacity

Rochdale Healthcare (NHS) Trust v C (1997)

The consultant obstetrician believed that without a caesarean section both C and her baby would die. C refused consent because a previous caesarean delivery had left her with backache and a painful scar. She declared that she would rather die than have another caesarean. No psychiatric opinion was available but the consultant obstetrician believed that C was competent.

Held: a non-consensual caesarean section was in C's best interests and would be lawful as C temporarily lacked competence.

Johnson J stated:

> [She] was in the throes of labour with all that is involved in terms of pain and emotional stress. I concluded that a patient who could, in those circumstances, speak in terms which seemed to accept the inevitability of her own death, was not a patient who was able properly to weigh up the considerations that arose so as to make any valid decision.

Note

This decision is only first instance and is open to criticism because the judge made a decision about C's competence based on her actual decision rather than her decision making capacity. Also, he overruled the consultant obstetrician's opinion without even meeting—let alone assessing—C. In *Re MB,* although Butler-Sloss LJ considered this decision, she merely noted that there was little evidence to justify his decision but her only comment was: 'Nonetheless he made the declarations sought.' Thus, the decision appears to have been accepted without disapproval by the Court of Appeal.

Think point

What are the effects of this judgment on the autonomy of labouring women? Should the same reasoning be applied to any patient who is in pain?

3.1.7 Competence only requires the ability to understand information in 'broad terms'

Cambridgeshire County Council v R (An Adult) (1995)

The family of a 21 year old woman with a learning disability, who had been in local authority care since the age of 10, were seeking to re-establish contact with her. She had been taken into care after her father had been convicted of serious sexual offences against her. The Local Authority sought declarations that it would be lawful to prevent the family having contact without the Local Authority's consent and to prevent them from trying to persuade her to return to the family home.

Held: application refused. The court had no right to make a declaration which would interfere with her legal right of freedom of association where there was no demonstrable threat of violence or other injury to her person. Also, there was insufficient evidence to prove that she was incapable of making the decision for herself.

Hale J stated:

> The question to be decided is whether the person's mental condition is such that he does not sufficiently understand the nature, purpose and effects of the proposed treatment…the Law Commission…proposed that the relevant information should be contained in an explanation 'in broad terms and simple language' so that people should not be expected to be able to understand everything about a complicated decision as long as they could understand the essentials.

The Law Commission (1995) recommended that:

> …a person should not be regarded as unable to understand the information relevant to a decision if he or she is able to understand an explanation of that information in broad terms and simple language (Draft Bill, cl 2(3)).

Note

Although the Law Commission's recommendations are not legally binding, Hale J seems to have accepted them in principle (see above). Also, it is logical to suggest that the requirement for competence should mirror the requirement of information disclosure for a 'real' consent. There would be little point in requiring someone to demonstrate a greater level of competence than that needed to understand the actual information they will be given.

Think point

(1) How does this point fit with Lord Donaldson MR's view that the standard of competence should be higher when the gravity of the decision is greater—a risk-related standard (see Chapter 2)?
(2) Should competence vary with the risk or the complexity of the decision?

3.2 Incompetent patients and consent

3.2.1 Spouses and relatives have no power to consent on behalf of incompetent adults

Re S (Hospital Patient: Courts Jurisdiction) (1995) CA

S had a wife and adult son living in Norway. He had set up home in England with Mrs A. She had his power of attorney to operate his bank accounts. S had a stroke. Mrs A used her power of attorney to pay for hospital bills. S's wife and son arranged to fly him to Norway. Mrs A obtained an injunction to prevent this transfer. She then applied for a declaration that it would be unlawful to take him out of England because it would not be in S's best interests.

Held: granted at first instance and upheld by the Court of Appeal.

Hale J stated (High Court approved by the Court of Appeal):

> Yet although his [the son] relationship to the patient is a close one, and his wishes are of course worthy of respect, he has no more legal right to decide the patient's future than has the plaintiff [Mrs A].

Re T (Adult: Refusal of Medical Treatment) (1992) CA

For the facts and decision, see 2.3.1.

Lord Donaldson MR stated:

> There seems to be a view in the medical profession that in such emergency circumstances the next of kin should be asked to consent on behalf of the patient … This is a misconception because the next of kin has no legal right either to consent or to refuse consent.

3.2.2 The court has no jurisdiction to consent on behalf of incompetent adult patients

F v West Berkshire HA (1989) HL

The plaintiff was a 36 year old woman with a severe mental incapacity. She was a voluntary in-patient at a mental hospital and had formed a sexual relationship with a male patient. Psychiatric evidence suggested that it would be disastrous if she became pregnant. The medical staff wanted to sterilise her since other forms of contraceptive were unsuitable as either dangerous to her health or difficult for her to be able to use effectively. A declaration was sought that it would be lawful to perform the sterilisation.

Held: the court had no jurisdiction either by statute or derived from the Crown as *parens patriae* to give or withhold consent on behalf of an incompetent adult.

Note

(1) This case may also be found referred to as *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1.
(2) The position will change in the future when the Government legislates on the basis of the Lord Chancellor's Report, *Making Decisions* (see below for summary).

3.3 Advance directives

Note

In addition to what is discussed below, an advance directive must conform with all the other requirements of consent. Thus, the patient must have been competent when it was made, it must have been made voluntarily and with a broad understanding of the implications. As with ordinary consent, an advance directive does not have to be in writing *(Re T (Adult: Refusal of Medical Treatment)* (1992)) but a written directive may be more certain (see below) than a verbal one.

3.3.1 Advance directives are legally binding

Airedale NHS Trust v Bland (1993) HL

Anthony Bland suffered a severe crush injury in the Hillsborough disaster. He had been in a persistent vegetative state (PVS) for three and a half years. There was no hope of recovery. The Health Authority sought declarations that it would be lawful to withdraw and withhold life-preserving treatment.

Held: it would be lawful to withhold life-preserving treatment if it was not in the patient's best interests that his life should be prolonged. Doctors were not under an absolute obligation to prolong life regardless of the circumstances or the patient's quality of life.

Lord Keith argued *(obiter)* that the patient's right to give or withhold consent:

> …extends to the situation where the person, in anticipation of his…entering into a condition such as PVS, gives clear instructions that in such event he is not to be given medical care, including artificial feeding, designed to keep him alive.

Re AK (Medical Treatment: Consent) (2001)

AK was a 19 year old man suffering from motor neurone disease (a progressive and incurable neurological disease). He was ventilator dependent and only able to communicate by blinking his eyelids to indicate 'yes' or 'no'. By this method of communication, AK requested that the doctors should withdraw treatment two weeks after he lost the ability to communicate. He was aware that this would result in his death. The doctors sought a declaration that it would be lawful to discontinue treatment as directed by the patient.

Held: declaration granted.

Hughes J stated:

> It is…clearly the law that the doctors are entitled…[to treat the patient] if it is known that the patient, provided he was of sound mind and full capacity, has let it be known that he does not consent and that such treatment is against his wishes. To this extent an advance indication of the wishes of the patient of full capacity and sound mind are effective.

Note

Hughes J argued that particular care had to be taken to ensure that the anticipatory wishes still held true, bearing in mind: how long ago the directive was made; the way in which the directive was expressed (verbally, written, etc); and all the circumstances that pertained at the time.

3.3.2 To be binding, advance directives must be certain

Re T (Adult: Refusal of Medical Treatment) (1992) CA

For the facts, see 2.3.1.

Held: the circumstances under which T had refused the blood transfusion were different from the present circumstances and so her refusal was not binding. Other factors were also relevant (see Chapter 2).

Lord Donaldson MR stated:

> …contact with the next of kin may reveal that the patient has made an anticipatory choice which, if *clearly established and applicable in the circumstances*—two major 'ifs'—would bind the practitioner [emphasis added].

3.3.3 Broad catch-all phrases such as, 'under any circumstances' are sufficiently certain even when the patient's life is threatened

Mallette v Shulman (1990) Ontario CA

The plaintiff was a Jehovah's Witness admitted to hospital following a road traffic accident. She was unconscious and so unable to give or refuse consent. She was carrying a card that stated: 'As one of Jehovah's Witnesses with firm religious convictions, I request that no blood or blood products be administered to me under any circumstances. I fully realise the implications of this position.' The doctor ignored these instructions and administered a life saving transfusion.

Held: the doctor was liable for a battery.

Robbins JA stated:

> A doctor is not free to disregard a patient's advance instructions any more than he would be free to disregard instructions given at the time of the emergency.

Think point

(1) Would it make any difference if a woman of child bearing age became pregnant having drafted an advance directive when she was not pregnant?
(2) Under what circumstances would a doctor be ethically justified in ignoring an advance directive?

3.3.4 The court may grant an injunction to ensure that an advance directive is complied with

Re C (Adult: Refusal of Treatment) (1994)

For the facts, see 2.1.2.

Held: an injunction was granted to prevent the amputation of C's leg. The injunction included future circumstances such that an amputation could not be performed without his written consent.

3.3.5 An advance directive is binding until it is specifically revoked

Re C (Adult: Refusal of Treatment) (1994)

For the facts see, 2.1.2.

Held: the injunction granted would protect C's refusal of the amputation until it was revoked in writing.

3.3.6 Doctors are not obliged to comply with advance directives that request particular treatments

In *Making Decisions,* the Lord Chancellor states:

> An advance statement can request specific treatments. It is an important principle that health professionals are not legally bound to provide that treatment if it conflicts with their professional judgment.

Note

As the Lord Chancellor notes, this statement reflects the current position for competent patients in the common law (see Chapter 11) and there is no reason why an advance directive should command special treatment.

3.3.7 Doctors may not be obliged to comply with advance directives which are contrary to public policy such as the refusal of basic care

Law Commission Report No 231, 1995, para 5.34

We *recommend* that an advance refusal of treatment should not preclude the provision of 'basic care', namely care to maintain bodily cleanliness and to alleviate severe pain, as well as the provision of direct oral nutrition and hydration (Draft Bill, cl 9(7)(a) and (8)).

Note

There is no case law on this and the Government have no plans to introduce legislation on advance directives. The Law Commission recommendations are not legally binding but may influence the judiciary if a case ever came before them. Also note that this recommendation relates to direct oral nutrition such as spoon feeding or via a straw but both the BMA (Statement on Advance Directives (1992)) and Law Commission (Consultation Paper No 129 (1993) para 3.26) states that an advance directive should be able to preclude artificial feeding such as through a naso-gastric tube.

3.4 The incompetent patient and the doctrine of necessity

3.4.1 Justification of treating incompetent adults is found in the doctrine of necessity

F v West Berkshire HA (1989) HL

For the facts, see 3.2.2.

Held: the court had jurisdiction to make a declaration that the operation was lawful because it was in the patient's best interests.

Lord Goff stated:

> On what principle can medical treatment be justified when given without consent? We are searching for a principle on which, in limited circumstances, recognition may be given to a need, in the interests of the patient, that treatment should be given to him in circumstances where he is (temporarily or permanently) disabled from consenting to it. It is this criterion of a need which points to the principle of necessity as providing justification.

Note

Lord Griffiths argued that the justification was that medical treatment of incompetent adults was in the public interest.

3.4.2 If a court declares a treatment as lawful then the doctors may use reasonable force to carry out that treatment

Norfolk and Norwich Healthcare (NHS) Trust v W (1996)

A 32 year old woman was admitted in a state of arrested labour. She had a past history of psychiatric treatment 'marked by non-co-operation by her

with those seeking to help her'. The psychiatrist opined that she was not suffering from a mental disorder under the MHA 1983 and she was capable of instructing a solicitor. However she had persisted throughout the day in denying her pregnancy. On the basis of the *Re C* test, the psychiatrist determined that she was unable to weigh treatment information in the balance and hence lacked the capacity to consent There were two potential risks if the delivery of her baby was not assisted: the fetus might be deprived of oxygen and possibly die *in utero;* and secondly, the scar from her previous caesareans might rupture. A declaratory order for a caesarean was sought.

Held: the court had a common law power to authorise the use of reasonable force. This was provided there was a 'necessity to act…[and] the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person' (*per* Johnson J).

3.4.3 The doctrine of necessity requires that the treatment is both necessary and in the patient's best interests

F v West Berkshire HA (1989) HL

For the facts and decision, see 3.2.2.

Lord Goff stated:

> …to fall within the principle [of necessity], not only (1) must there be a necessity to act when it is not practicable to communicate with the assisted person, but also (2) the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person.

3.4.4 The patient's best interests should be interpreted broadly to include emotion, psychological and social factors

Re Y (Adult Patient) (Transplant: Bone Marrow) (1996)

The plaintiff suffered from non-Hodgkin's lymphoma. She required a bone marrow transplantation. The defendant, Y, was one of the plaintiff's three sisters. She was a severely mentally retarded adult. The plaintiff sought a declaration that it would be lawful to perform blood tests and a bone marrow harvest despite Y being unable to give consent.

Held: declaration granted. The procedures would be lawful as in the patient's best interests. The family was particularly close and Y benefited from family visits. The plaintiff's death would adversely affect the health of Y's mother and may result in fewer visits or loss of contact with Y which would be

detrimental to her. There was no real long term risk and the disadvantages, to Y, of the procedure were small. Thus, the procedure would provide emotional, psychological and social benefits to Y and so would be in her best interests.

Connell J stated:

> …if the transplant occurs, this is likely to improve the defendant's relationship with her mother who in her heart clearly wishes it to take place and also to improve her relationship with the plaintiff who will be eternally grateful to her.

R-B (A Patient) v Official Solicitor (2000) CA

The mother of a 28 year old male with Down's syndrome applied to the court for a declaration that a sterilisation operation would be lawful. The patient had indicated that he did not want the operation. At first instance the application was refused. His mother appealed.

Held: appeal dismissed. It had not been demonstrated that the operation would be in his best interests which encompassed medical, emotional and all other welfare issues.

Thorpe LJ considered that counterbalancing 'dis-benefits' included 'the apprehension, the risk and the discomfort inherent in the operation'.

Note

In *Making Decisions,* the Lord Chancellor has indicated that the following factors will provide a statutory framework for determining the patient's best interests:

(1) the ascertainable past and present wishes of the person and the factors the person would consider if able to do so;
(2) the need to permit and encourage the person to participate…in any decision affecting him;
(3) the views of other people whom it is appropriate and practical to consult;
(4) whether the purpose…can be as effectively achieved in a manner less restrictive of the person's freedom of action;
(5) whether there is a reasonable expectation of the person recovering capacity…in the reasonably foreseeable future; and
(6) the need to be satisfied that the wishes of the person without capacity were not the result of undue influence.

3.4.5 The doctrine of necessity cannot be used to override a competently made advance directive

F v West Berkshire HA (1989) HL

For the facts and decision, see 3.2.2.

Lord Goff stated:

> I wish to observe that officious intervention cannot be justified by the principle of necessity…nor can it be justified when it is contrary to the known wishes of the assisted person, to the extent that he is capable of rationally forming such a wish.

3.4.6 The doctrine of necessity also applies to diagnostic procedures

Re H (Mental Patient: Diagnosis) (1993)

The patient suffered from schizophrenia. She had recently developed epilepsy and there was the possibility of a brain tumour. One of the diagnostic procedures would require the injection of contrast and a brain scan while the patient was under a general anaesthetic. The Health Authority sought a declaration that the procedure was lawful as being in the patient's best interests.

Held: application for declaration dismissed. No distinction should be drawn between therapeutic and diagnostic procedures. A declaration was not necessary because the doctors could lawfully perform the procedure providing it was in the patient's best interests.

3.5 Non-therapeutic medical interventions and the role of the court

3.5.1 The court can grant a declaration that a proposed treatment is lawful

F v West Berkshire HA (1989) HL

For the facts and decision, see 3.2.2.

Lord Goff stated:

> I can see no procedural objection to the declaration granted by the judge, either as a matter of jurisdiction or as a matter of exercise of the discretion conferred by the relevant rule of the Supreme Court, Ord 15, r 16. Rule 16 provides: 'No action or other proceeding shall be open to objection on the ground that a merely declaratory judgment or order is sought thereby, and the Court may make binding declarations of right whether or not any consequential relief is or could be obtained.'

Note

Lord Goff argued that the following were required before a court would exercise its discretion: (1) a real question; (2) about present circumstances and not regarding future rights; (3) that the plaintiff has a proper interest in; and (4) where the declaration is sought with proper argument.

Think point

Does a declaration alter the legality of the proposed act?

3.5.2 There is no legal requirement but in certain cases it would be good practice to seek the court's approval

F v West Berkshire HA (1989) HL

For the facts and decision, see 3.2.2.

Lord Bridge drew a distinction between curative or prophylactic treatment, which does not require the court's approval, and non-therapeutic treatment.

Lord Brandon gave six reasons why it would be good practice to involve the court in cases of non-therapeutic sterilisation: (1) it is 'in most cases…irreversible'; (2) it will deprive the woman of the 'fundamental… right to bear children'; (3) deprivation of this right raises important moral and emotional considerations; (4) there is a greater risk of a wrong decision without the court's involvement; (5) there is a risk the operation may be performed 'for improper reasons or with improper motives'; and (6) the court's involvement will protect the doctors.

Note

(1) The House of Lords in Bland decided that it would be good practice to seek the court's approval before withdrawing nutrition and other life-preserving treatment from patients in PVS.
(2) The Official Solicitor has produced Practice Notes for both sterilisation ([1996] 2 FLR 111) and PVS ([1996] 2 FLR 375) which reiterate the requirement of the court's approval 'in virtually all cases'.

Think point

Under what circumstances, if at all, should clinical research procedures on incapacitated patients require the court's approval? Can research on incapacitated patients ever be ethically justified?

3.5.3 Where there are therapeutic reasons for an operation the court's approval is not necessary

Re GF (Medical Treatment) (1992)

GF was a severely mentally disabled adult who suffered from excessively heavy menstrual periods which she was unable to cope with. The recommended treatment was a hysterectomy but this would have the incidental effect of sterilising her.

Held: no declaration was required where two medical practitioners were satisfied that: (1) the operation was necessary for therapeutic purposes; (2) the operation was in the best interests of the patient; and (3) there was no practicable, less intrusive means of treating the condition.

Note

In *Re SG (Adult Mental Patient: Abortion)* (1991), the High Court held that an abortion was not a category of case that required the courts approval, especially as it was closely regulated by the Abortion Act 1967.

3.5.4 A treatment will not be declared lawful if, in all the circumstances, it is not in the patient's best interests

Re LC (Medical Treatment: Sterilisation) (1997)

LC was moved to a small residential home with an excellent reputation after she had been sexually abused at her previous home. Her mother, worried in case LC was assaulted again, sought a declaration that a sterilisation would be lawful.

Held: application dismissed.

Thorpe J stated:

> The present level of care and supervision at X House is of such an exceptionally high quality that it would not be in LC's best interest to impose upon her a surgical procedure which is not without risks nor without painful consequences … Of course, circumstances may change… But…leave could not be justified upon the basis of some vague and unsubstantiated fear that LC in future will be exposed to risks from which she is presently protected.

3.5.5 It is the judge and not the doctor who decides what is in the patient's best interests

Re A (Male Sterilisation) (2000) CA

The mother of a 28 year old male with Down's syndrome applied to the court for a declaration that a sterilisation operation would be lawful. The patient

had indicated that he did not want the operation. At first instance the application was refused. His mother appealed.

Held: appeal dismissed. The declaration would not be granted.

Butler-Sloss LJ distinguished the doctor's duty governed by the *Bolam* test as the professional standard of care and the doctor's duty to act in the best interests of the incompetent patient. In other words, the *Bolam* test applies to determining the range of appropriate treatment options but does not apply to determining the patient's best interests. She stated:

> …in the case of an application for approval of a sterilisation operation, it is the judge, not the doctor, who makes the decision that it is in the best interests of the patient that the operation be performed.

Note

This only applies to cases that reach the courts. Obviously, most best interest judgments in practice will be made by healthcare professionals. But they should bear in mind that, if their decision is challenged, it is the court that will have the final word as to the patient's best interests.

3.5.6 There can only be one 'best option'

Re S (Adult Patient: Sterilisation) (2000) CA

S was a 29 year old woman with severe learning difficulties. She was distressed by her menstrual periods but had a phobia about hospitals. Her mother applied for an order that it would be lawful to perform a sterilisation operation or hysterectomy on S. At first instance, the judge held that sterilisation was not in her best interests because, while it would protect her from pregnancy, it would not reduce her menstrual problems. The insertion of a contraceptive coil would achieve both of these ends but would have to be replaced every five years, which would require repeated general anaesthetics. A subtotal hysterectomy would achieve the same result without the need for further or repeated interventions and be the best option. The doctors favoured the coil while the mother favoured the hysterectomy. The judge held that either would be lawful and left it to the mother to determine, with the doctors, which option should be chosen. An appeal was made on behalf of the patient.

Held: appeal allowed. While many different courses of action may be lawful 'there could only logically be one best option and it was for the court to decide'. Once the doctors had proposed a range of acceptable options the court should pick the one which was in the patient's best interests. In this case it would be the less invasive and less permanent option of the contraceptive coil.

On the relevance of the *Bolam* test, Dame Butler-Sloss P stated:

> I would suggest that the starting point of any medical decision would be the principles enunciated in the *Bolam* test and that a doctor ought not to make any decision about a patient that does not fall within the broad spectrum of the *Bolam* test. The duty to act in accordance with responsible and competent professional opinion may give the doctor more than one option since there may well be more than one acceptable medical opinion. When the doctor moves on to consider the best interests of the patient he/she has to choose the best option …the best interests test ought, logically, to give only one answer…the principle of best interest as applied by the court extends beyond the considerations set out in… *Bolam*…[and] will incorporate broader ethical, social, moral and welfare considerations.

Where a declaration is sought form the court, then it is for the judge to make the decision as to the best option.

Note

The Court of Appeal distinguished *Re ZM & OS (Sterilisation: Best Interests)* (2000) because in *Re S*, medical opinion was unanimous while in *Re ZM*, all four medical experts disagreed.

3.6 Summary of the proposals in the Lord Chancellor's Report *Making Decisions* that will form the basis of future legislation

(1) Applies to people without capacity aged 16 or over.
(2) Advance directives will not be the subject of legislation since they are better governed by the flexible approach of the common law and professional codes of practice.
(3) There will be a statutory presumption against lack of capacity.
(4) There will be a new statutory definition of incapacity based on the 'functional' approach proposed by the Law Commission (see 3.1.2). 'A person is to be regarded as unable to make a decision by reason of mental disability if the disability is such that, at the time when the decision needs to be made, the person is unable to understand or retain the information relevant to the decision, or unable to make a decision based on that information.'
(5) There will be statutory guidance on how to determine the person's best interests (see 3.4.4).

(6) There will be a general authority 'to do anything for the personal welfare or healthcare…if it is in all the circumstances reasonable' provided it is reasonably believed by the decision maker to be in the incapacitated person's best interests. This general authority will be subject to the decision of a court appointed manager or a person who holds the incapacitated person's Continuing Power of Attorney.
(7) A new system of Continuing Powers of Attorney (CPA) will be set up that will allow a competent adult to give someone the CPA to make healthcare decisions on his behalf once he has become incapacitated. This will not cover the withdrawal of artificial nutrition and hydration unless actually specified.
(8) The court will not be able to appoint a substitute attorney but will be able to make decisions on behalf of the incapacitated person or appoint a manager to make those decisions (the manger will be obliged to act in the incapacitated person's best interests and is unlikely to have the power to refuse consent to healthcare).
(9) The court will have the power to make declarations about capacity.

4 Children and Medical Treatment

4.1 Consent and children over the age of 16

4.1.1 There is a statutory presumption that children over the age of 16 are competent to give legally effective consent

Section 8 of the Family Law Reform Act 1969

(1) The consent of a minor who has attained the age of 16 years to any surgical, medical or dental treatment which, in the absence of consent would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.

4.1.2 'Treatment' under the Act includes diagnostic procedures and ancillary treatments

Section 8 of the Family Law Reform Act 1969

(2) In this section 'surgical, medical or dental treatment' includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure (including, in particular, the administration of an anaesthetic) which is ancillary to any treatment as it applies to that treatment.

Note

'Treatment' probably encompasses all medical and dental procedures that would ordinarily be considered as treatment. It probably does not include purely cosmetic surgery, research or organ donation (Montgomery (1997)).

4.1.3 Parental consent for treatment on children between the ages of 16 and 18 will still be a legally effective consent

Section 8 of the Family Law Reform Act 1969

(3) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.

Note

This section also allows the common law *Gillick* decision to apply to 16–18 year old children for medical procedures that fall outside the provisions of the Act.

4.1.4 Parental consent can override a refusal of consent made by a competent child between the ages of 16 and 18

Re W (A Minor) (Medical Treatment) (1992) CA

W was a 16 year old girl with anorexia nervosa. She was under the care of the Local Authority in an adolescent residential unit. Because her condition had worsened the Local Authority sought the court's approval to transfer her to a specialist unit. W refused consent and claimed that s 8 of the Family Law Reform Act 1969 gave her the same right as an adult to refuse treatment.

Held: (disregarding the question of W's competence—see 7.1.2) s 8 of the Family Law Reform Act 1969 gave the child the right to give consent but did not take that right away from the person(s) exercising parental responsibility. Only one consent is necessary and that may be given by the child or the person with parental responsibility.

Lord Donaldson MR suggested that consent under this section could be seen as analogous to a:

> …legal 'flak jacket' which protects the doctor from claims by the litigious whether he acquires it from his patient who may be a minor over the age of 16, or a '*Gillick* competent' child under that age or from another person having parental responsibilities which include a right to consent to treatment of the minor. Anyone who gives him a flak jacket (that is, consent) may take it back, but the doctor only needs one and, so long as he continues to have one, he has the legal right to proceed.

Think point

Is Lord Donaldson's view logically consistent with the Act, the common law view of consent and the moral basis for consent?

Note

Section 1 of the Family Law Reform Act allows that individuals over the age of 18 are no longer minors and thus have the right to give or refuse consent the same as any other adult person.

4.2 Consent and children under the age of 16

4.2.1 Children under the age of 16 may give consent to a medical procedure providing they have sufficient maturity to understand all the implications

Gillick v West Norfolk and Wisbech AHA (1986) HL

The Department of Health and Social Security issued guidance to Area Health Authorities concerning family planning provisions. The guidance included advice concerning children under 16. Although the advice stressed the importance of involving the child's parents, it added that in exceptional circumstances the doctor could prescribe contraceptives without informing the parents. Mrs Gillick sought a declaration that the guidance was unlawful. The application failed at first instance but succeeded in the Court of Appeal.

Held: by a majority of 3:2, the appeal was allowed and the declaration sought by Mrs Gillick was refused.

Lord Fraser laid down five requirements that should be satisfied before a doctor concludes that he may proceed without the parents' consent:

(1) that the girl (although under 16 years of age) will understand his advice;
(2) that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice;
(3) that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment;
(4) that unless she receives contraceptive advice or treatment, her physical or mental health or both are likely to suffer;
(5) that her best interests require him to give her contraceptive advice, treatment or both without parental consent.

Lord Scarman stated:

> I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child

seeking advice has sufficient understanding and intelligence to enable him or her to understand fully what is proposed.

He continued:

> It is not enough that she should understand the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved. There are moral and family questions, especially her relationship with her parents, long term problems associated with the emotional impact of pregnancy and its termination, and there are risks to health of sexual intercourse at her age, risks which contraception may diminish but cannot eliminate.

Note

The BMA (1993) states: 'In the BMA's view, the tendency to regard mature young people as autonomous in their own right is a very welcome trend which should not be undermined.'

4.2.2 The court will be slow to find the child *Gillick* competent where their decision puts their life in jeopardy

Re E (A Minor) (Wardship: Medical Treatment) (1993)

E was a 16 year old Jehovah's Witness suffering from leukaemia. He required blood transfusions which he refused. Both his parents were also Jehovah's Witnesses and supported his refusal. The hospital authority made him a ward of court and applied for the court's approval to the treatment.

Held: the treatment was approved.

Ward J argued that, although he was intelligent enough, he lacked sufficient understanding to be *Gillick* competent. 'He may have some concept of the fact that he will die, but as to the manner of his death and the extent of his and his family's suffering I find he has not the ability to turn his mind to it.' He also stated that the court 'should be very slow to allow an infant to martyr himself.

Note

The *Gillick* requirements of competence are far more stringent than those required for adults. Many adults deemed competent would fail them. The *Re E* case had a sad outcome in that E waited until he was 18 and then refused any further consent to the blood transfusions and subsequently died.

4.2.3 Parental consent can override the refusal of consent by a *Gillick* competent child

Re R (A Minor) (Wardship: Consent to Treatment) (1991) CA

R was a 15 year old girl with a fluctuating mental disorder that varied between lucidity and 'florid psychotic behaviour'. She had been voluntarily placed in local authority care after a fight with her father but following violent and suicidal psychotic behaviour she was placed in an adolescent psychiatric unit. While taking medication she became clear, lucid and rational, but during these periods she refused consent to her medication. The Local Authority started wardship proceedings and applied for leave for the psychiatric unit to administer non-consensual medication.

Held: in exercising its wardship jurisdiction, the High Court had power to consent to medical treatment of a minor ward who was competent to consent but who had refused consent or was not asked.

Lord Donaldson MR argued that the *Gillick* decision did not remove the right of consent from the child's parents and stated:

> …consent by itself creates no obligation to treat. It is merely a key which unlocks a door. Furthermore, whilst in the case of an adult of full capacity there will usually only be one keyholder, namely the patient, in the ordinary family unit, where a young child is the patient, there will be two keyholders, namely the parents, with several as well as a joint right to turn the key and unlock the door… The parents can only have a right of determination if either the child has no right to consent, that is, is not a keyholder, or the parents hold a master key which could nullify the child's consent.

He concludes:

> There can be concurrent powers to consent. If more than one body or person has a power to consent, only a failure to, or refusal of, consent by all having the power will create a veto… A '*Gillick* competent' child or one over the age of 16 will have a power to consent, but this will be concurrent with that of a parent or guardian.

Note

This decision was heavily criticised and Lord Donaldson MR later regretted his keyholder analogy. He subsequently rejected it in favour of the legal flak jacket. See *Re W* (4.1.4).

4.2.4 The person with parental responsibility cannot override the consent of a *Gillick* competent minor

Re R (A Minor) (Wardship: Consent to Treatment) (1991) CA

For the facts and decision, see 4.2.3.

Lord Donaldson MR argued that the rights of the competent child and the parents were concurrent. This logically means that a consent from any of the relevant parties will be sufficient and the decisions of the other parties become irrelevant. However, the child's wishes should always be borne in mind even where they are not determinative.

Re P (A Minor) (1982)

A 15 year old girl, who already had one baby and resided in a mother and baby unit, wanted a termination of her pregnancy. Her parents objected to the abortion because they wished to care for the child, and P's father also objected on religious grounds.

Held: P would be allowed to have the termination despite parental objections.

Note

P was a ward of court and the final decision was based on what would be in her best interests. Also, because the termination was under the Abortion Act 1967, the judge was unable to make the decision solely on the basis of what P wanted.

4.2.5 Even where the child is not competent, the doctor should take the child's views into account

Re R (A Minor) (Wardship: Consent to Treatment) (1991) CA

For the facts and decisions, see 4.2.3.

Lord Donaldson MR commenting on the doctor's decision whether to treat a child stated:

> In forming that judgment, the views and wishes of the child are a factor whose importance increases with the increase in the child's intelligence and understanding.

The BMA (1993) states:

> Even when children do not have sufficient understanding to make a valid decision, involving them in an appropriate way, so as to gain their co-operation, is seen as valuable.

Think point

Is the BMA's justification for involving children in their treatment decisions sufficient? Are there any other reasons why children should be involved?

4.3 Limits to parental consent

4.3.1 Parents may only give consent to treatment that is lawful

Parents cannot give a legally valid consent to treatment which is contrary to public policy or outlawed by statute. This includes risky research procedures that hold no benefit for the child and, for example, female circumcision, which is outlawed by the Prohibition of Female Circumcision Act 1985.

4.3.2 Parents have the power to give consent but no right to insist on treatment

Re J (A Minor) (Wardship: Medical Treatment) (1990) CA

J was a 'grossly handicapped' child who had been made a ward of court. The medical evidence suggested that he would develop spastic quadriplegia and would be deaf, blind and severely intellectually impaired. He would, however, be able to feel pain. Although he was not expected to survive into late adolescence, he was not terminally ill. After two previous episodes requiring ventilation, the 'medical prognosis was that any further collapse which required ventilation would be fatal'. The medical staff sought a court order as to whether he should be re-ventilated if the need arose. At first instance the judge made an order that J should be 'treated with antibiotics if he developed a chest infection but should not be re-ventilated if his breathing stopped, unless the doctors caring for him deemed it appropriate given the prevailing clinical situation'.

Held: appeal dismissed. The doctors could lawfully withhold re-ventilation.

Lord Donaldson MR stated, *obiter:*

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

Re J (A Minor) (Child in Care: Medical Treatment) (1992) CA

J was a profoundly mentally and physically handicapped toddler. He suffered from cerebral palsy, blindness and epilepsy. The child's physician argued that it would be medically inappropriate and cruel to artificially ventilate the child. At first instance, the judge made an interim order requiring the Health Authority to provide all available treatment to J including 'intensive resuscitation'. J's mother sought to uphold the order and relied on a report by an expert in child health from a different London teaching hospital whose view opposed that of the child's physician.

Held: appeal allowed. The Health Authority would not be required to ventilate the child. The Court of Appeal held:

> The court would not exercise its inherent jurisdiction over minors by ordering a medical practitioner to treat the minor in a manner contrary to the practitioner's clinical judgment, since to do so would require the practitioner to act contrary to the fundamental duty which he owed to his patient, which… was to treat the patient in accordance with his own best clinical judgment.

4.3.3 Parental power of consent is limited to treatment that is in the best interests of the child

Re B (1987) HL (The Jeanette Case)

Jeanette was a 17 year old voluntary patient in a local authority home. She suffered a moderate degree of mental handicap and had the intellectual capacity of a 6 year old. She was beginning to show signs of sexual awareness and a sexual drive. It was felt that she would be unable to cope with the demands of pregnancy, childbirth or child rearing. A court order was sought to allow Jeanette to be sterilised.

Held: order granted.

Lord Templeman suggested, *obiter,* that consent to the sterilisation of a minor was beyond the powers of the parent. He stated:

> In my opinion sterilisation of a girl under 18 should be carried out with the leave of a High Court judge. A doctor performing a sterilisation operation with the consent of the parents might still be liable in criminal, civil or professional proceedings. A court exercising the wardship jurisdiction emanating from the Crown is the only authority which is empowered to authorise such a drastic step as sterilisation after a full and informed investigation.

This has been criticised as wrong in principle but it has been approved at first instance (*Re P* (1989)). In the Court of Appeal hearing of *F v W Berkshire sub nom Re F* (1989), Lord Donaldson suggested that, although it should be sought, a lack of court approval would not render the operation unlawful. In

the same hearing, Butler-Sloss LJ argued that court approval was a requirement. Montgomery (1997) suggests:

> …until further clarification emerges, it would be safest to regard the sterilisation of minors without court approval as unlawful.

Note

This only applies to non-therapeutic sterilisations, where the issue of the child's best interests is a complex balance, best judged by the independent authority of the court.

4.3.4 Parental consent to treatment may be valid even if it is not in the child's best interests providing it is reasonable and not contrary to the child's best interests.

S v McC; W v W(1972) HL

Both cases involved the question of whether the court should grant an order authorising a blood test to determine the paternity of the child. The first of the two was an appeal against such an order; the second case was an appeal against the refusal of the lower courts to grant the order.

Held: first appeal dismissed; second appeal allowed. The order for a paternity test was granted in both cases.

Lord Reid stated:

> …even if one accepts the view that in ordering, directing or permitting a blood test the court should go no further than a reasonable parent would go, surely a reasonable parent would have some regard to the general public interest and would not refuse a blood test unless he thought that would clearly be against the interests of the child.

Note

This case was decided before the Family Law Reform Act 1969 came into force. In *Re O (A Minor) (Blood Tests: Constraint)* (2000), Wall J held that s 21 of that Act gave the person with parental responsibility the absolute right to give or refuse consent to blood sampling for the purposes of determining paternity (s 20). Wall J suggested, however, that: 'If Parliament does not implement reform, the law in this area will continue not to serve the best interests of children. In these circumstances I anticipate that reform may need to be achieved when the Human Rights Act 1998 comes into force by the point being taken that Pt III of the Act of 1969 is not human rights compliant.' This case is incompatible with the decision in *Re R (A Minor) (Blood Test: Constraint)* (1998), which held that such an order could be made. In *Re H (A Minor)*

(Blood Tests: Parental Rights) (1997), the Court of Appeal held that s 20(1) did not empower the court to order blood tests, but merely permitted it to make a direction for the use of blood tests to determine paternity. This somewhat contradictory case law is made obsolete by s 82 of the Child Support, Pensions and Social Security Act 2000, which amends ss 20–23 of the Family Law Reform Act 1969 and covers blood and other bodily samples and gives the power to direct that such samples may be taken from a minor without the consent of the responsible carer.

4.3.5 A parental decision to refuse consent must be respected by the health care professional, but may be challenged in court

Re A (Children) (Conjoined Twins: Surgical Separation) (2000) CA

For the facts and decision, see 4.5.

Ward LJ stated:

> Since the parents are empowered at law, it seems to me that their decision must be respected and, in my judgment, the hospital would be no more entitled to disregard their refusal than they are to disregard an adult patients' refusal. To operate in the teeth of the parents' refusal would, therefore, be an unlawful assault upon the child… There is, however, this important safeguard to ensure that a child receives proper treatment. Because the parental rights and powers exist for the performance of their duties and responsibilities to the child and must be exercised in the best interests of the child, 'the common law has never treated such rights as sovereign or beyond review and control'. (See *Gillick v West Norfolk and Wisbech AHA* (1986) *per* Lord Scarman.)

4.3.6 A person responsible for the care of a child may be able to give a valid consent to medical treatment

Section 3 of the Children Act 1989

(5) Where a person has care of a child, but lacks parental responsibility, that person may do 'what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare'.

B v B (A Minor) (Residence Order) (1992)

A grandmother (supported by the child's mother) applied for a residence order for her 11 year old granddaughter. The application was refused by the justices under s 1(5) of the Children Act 1989, which required that the court only make an order if it was better for the child than making no order at all. The decision was based on the fact that the child had been

permanently resident with the grandmother for most of her life and there was little risk of her mother removing the child from her home. The grandmother appealed.

Held: appeal allowed. Although the magistrates had been correct in their application of s 1(5), there was a new ground that must be considered. Since the grandparent did not have parental responsibility, the education authority was reluctant to accept her authority, there may be problems with consent to medical treatment, and the child was anxious about her future. Johnson J noted the provisions of s 3(5) of the Children Act 1989 but argued that, although those provisions clearly allowed the grandmother to give consent for the child's medical treatment, the professionals involved may be reluctant to proceed on the basis of such authority. Since the order would give parental responsibility to the grandmother, this would make the child's position more certain and secure.

4.4 The role of the court

4.4.1 The court may override a parental refusal of consent if it would be in the child's best interests

Re B (A Minor) (Wardship: Medical Treatment) (1990) CA

B was born suffering from Down's syndrome and an intestinal blockage. The intestinal blockage could be cured by operation but, without the operation she would die. Her parents refused consent because of her mental and physical handicaps. The Local Authority made her a ward of court and applied for the court's authorisation of the operation. At first instance, the judge held that the parent's wishes should be respected and he refused the operation. The Local Authority appealed.

Held: appeal allowed. The operation was authorised.

Dunn LJ stated:

> …although due weight must be given to the decision of the parents…the fact of the matter is that this court now has to make this decision. It cannot hide behind the decision of the parents or the decision of the doctors, and in making the decision, this court's paramount consideration is the welfare of this unhappy little baby.

Re S (A Minor) (Medical Treatment) (1993)

S suffered from leukaemia and required blood transfusions. S's parents were Jehovah's Witnesses, who refused consent on religious grounds. The Local Authority sought a court order permitting the treatment.

Held: order granted.
Thorpe J stated:

> …it is difficult to pursue the argument that the religious convictions of the parents should deny the child the chance of treatment.

4.4.2 In reaching a decision about the child's best interests the wishes of the parents are an important consideration

Re T (A Minor) (Wardship: Medical Treatment) (1997) CA

T had biliary atresia, a serious liver defect. Without a transplant he would not live for more than a couple of years. His mother (a health care professional) refused consent. At first instance, the judge authorised the operation. T's mother appealed.

Held: appeal allowed. The mother's refusal of consent was upheld. The Court of Appeal took account of the evidence of Dr P, who stated that the mother's commitment would be crucial to the success of the procedure.

Waite LJ stated:

> …it is the duty of the judge to allow the court's own opinion to prevail in the perceived paramount interests of the child concerned, but…in the last analysis, the best interests of every child include an expectation that difficult decisions affecting the length and quality of its life will be taken for it by the parent to whom its care has been entrusted by nature.

4.4.3 The parents' views as to the child's best interests are presumed to be correct, but this presumption may be rebutted

Re C (A Child) (HIV Testing) (2000)

C might have contracted infection with HIV (Human Immunodeficiency Virus, believed to be responsible for AIDS—Acquired Immune Deficiency Syndrome). Both parents refused consent to an HIV test, as they did not believe the conventional theories regarding the link between HIV and AIDs. The Local Authority sought an order that an HIV test be performed.

Held: application granted. Although there was a presumption that parental views of the child's best interests were correct, this presumption could be rebutted. Knowing the result could affect both the mother's decision to breast feed and also the provision of sound medical advice and was, therefore, in the child's best interests.

Note

The court argued that the rebuttable presumption in favour of the parents' views followed from s 1(5) of the Children Act 1989, which states that a court shall not make an order 'unless it considers that doing so would be better for the child than making no order at all. This was supported by the decision in *Re T* (see 4.4.2). Since making no order at all would leave the decision making responsibility with the parents, the court must be convinced that any order it was being asked to make must be sufficiently in the child's best interests to justify removing the decision making responsibility from the parents.

4.4.4 The court may override the decision of a competent child if it would be in their best interests

Re R (A Minor) (Wardship: Consent to Treatment) (1991) CA

For the facts and decisions, see 4.2.3.

4.4.5 Where the parents have given consent to the treatment, there is no need to seek a court order

Re K, W and H (Minors) (Medical Treatment) (1993)

Some adolescents treated in a specialised hospital unit complained about the practices of the unit. Only one of the complaints related to the use of medication. Patients were only admitted if parental consent to the unit's regime was obtained. The Health Authority set up a committee to investigate the unit. The committee advised the unit that the law was complex and any doubt about the question of consent to treatment should be resolved by seeking a court order. The hospital subsequently submitted applications for three highly disturbed patients despite the fact that they had the parents' full co-operation and consent.

Held: applications refused. Where the professionals had obtained the parents' consent, there was no risk of criminal or civil proceedings irrespective of whether the child was *Gillick* competent or not.

Thorpe J stated:

> Where more than one person has the power to consent, only a refusal of all having that power will create a veto.

4.4.6 The court will take the minor's views into account when deciding what treatment is in the child's best interests

Re W (A Minor) (Medical Treatment) (1992) CA

For the facts and decisions, see 4.1.4.

Balcombe LJ stated:

> Undoubtedly the philosophy…is that, as children approach the age of majority, they are increasingly able to take their own decisions concerning their medical treatment… Accordingly the older the child concerned, the greater the weight the court should give to its wishes, certainly in the field of medical treatment. In a sense, this is merely one aspect of the application of the test that the welfare of the child is the paramount consideration.

4.4.7 The greater the threat to the child's life the more likely the court will override a refusal of consent

Re W (A Minor) (Medical Treatment) (1992) CA

For the facts and decisions, see 4.1.4.

Balcombe LJ stated:

> …if the court's powers are to be meaningful, there must come a point at which the court, while not disregarding the child's wishes, can override them in the child's own best interests, objectively considered. Clearly such a point will have come if the child is seeking to refuse treatment in circumstances which will in all probability lead to the death of the child or to severe permanent injury.

Re M (Child: Refusal of Medical Treatment) (1999)

M was a 15 year old girl who had recently suffered heart failure and required a heart transplant. M's mother consented to the operation but M herself refused consent. M stated: 'Death is final—I know I can't change my mind. I don't want to die, but I would rather die than have the transplant and have someone else's heart, I would rather die with fifteen years of my own heart. If I had someone else's heart, I would be different from anyone else—being dead would not make me different from anyone else. I would feel different with someone else's heart, that's a good enough reason not to have a heart transplant.'

Held: the operation was authorised.

Johnson J stated:

> Whilst I was very conscious of the great gravity of the decision I was making in overriding M's wish, it seemed to me that in seeking to achieve what was best for her required me on balance to give the authority that was asked.

4.4.8 The court will not dictate the treatment to the doctor

Re J (A Minor) (Wardship: Medical Treatment) (1990) CA

See 4.3.2.

In *Re J (A Minor) (Wardship: Medical Treatment)* (1992), Bakombe LJ stated:

> I would also stress the absolute undesirability of the court making an order which may have the effect of compelling a doctor or health authority to make available scarce resources (both human and material) to a particular child, without knowing whether or not there are other patients to whom those resources might more advantageously be devoted.

See, also, *R v Cambridge District HA ex p B* (1995).

4.4.9 The court's reluctance to dictate treatment may be subject to the fact that the court must take decisions that are in the child's best interests

R v Portsmouth Hospitals NHS Trust ex p Carol Glass (1999) CA

A 12 year old boy with epilepsy, blindness and severe mental and physical handicaps developed a life threatening infection following a tonsillectomy. The doctors decided not to actively treat with antibiotics and administered morphine to make the boy more settled. The mother was opposed to this course of action and was unaware that a do not resuscitate order had been entered into the child's notes. He survived and his mother sought judicial review of the doctor's decision. Leave to apply for judicial review was denied by the High Court. Mrs Glass appealed.

Held: appeal denied. Judicial review was too blunt a tool to consider difficult situations such as these and a High Court order sought at the time of the altercation would have been more appropriate.

Lord Woolf laid out a number of principles that the court should take into account:

(1) The sanctity of life.
(2) The non-interference by the courts in areas of clinical judgment in the treatment of patients…where this can be avoided…
(3) The refusal of the courts to dictate appropriate treatment to a medical practitioner…subject to the power which the courts always have to take decisions in relation to the child's best interests. In doing so, the court takes fully into account the attitude of medical practitioners.
(4) That treatment without consent, save in an emergency, is trespass to the person.
(5) That the courts will interfere to protect the interests of a minor or a person under a disability.

He stated:

> The difficulty in this area is that there are conflicting principles involved. The principles of law are clearly established, but how you apply those principles to particular facts is often very difficult to anticipate.

Note

It is the third of Lord Woolf's principles that is a theoretically important reservation of the judicial right to order treatment. It is a notable modification of the statements in *Re J* (4.4.8). However, notice the importance placed on the medical view. It is suggested that, despite Lord Woolf's reservation of the judicial right to order treatment, the court is likely to place such an emphasis on the medical view of the child's best interests that they will rarely—if ever—dictate the treatment that a doctor must provide. The High Court has subsequently reiterated the view that 'it is well established that there can be no question of the court directing a doctor to provide treatment which he or she is unwilling to give and which is contrary to the doctor's clinical judgment' (*per* Cazalet J in *A NHS Trust v D* (2000)). See, also, *Royal Wolverhampton Hospitals NHS Trust v B* (2000).

4.5 The case of conjoined (Siamese) twins

Re A (Children) (Conjoined Twins: Surgical Separation) (2000) CA

The twins, Jodie and Mary, were conjoined twins. Mary had non functioning lungs and an abnormal heart capable of only 10% of its normal function. Mary was dependent on Jodie to supply her with oxygenated blood. The doctor's wanted to operate to separate the twins. It was accepted that without such an operation both twins would die, probably within three to six months. Following separation, it was probable that Jodie would survive with a reasonably normal life expectancy and quality. There was unlikely to be any mental handicap and the physical abnormalities were mostly correctable by surgical intervention. Mary, however, would inevitably die as a result of the operation and thus her life would be foreshortened by it. The parents refused consent to the operation for a number of reasons, both religious and practical. But their overriding reason was that they did not want one child to survive at the expense of the other, they could not choose between their children this way, and that their lives should be left in God's hands. The hospital applied to the court for a declaration that operation would be lawful. At first instance, the judge granted the declaration, since it would be in the best interests of both children: Jodie would survive and

Mary would be spared the prolongation of a life, which—because she was attached in such a manner to her twin—would be hurtful and distressing to her. The parents appealed.

Held: appeal dismissed.

(1) Every life has inherent and equal value regardless of any disability or reduction in the person's ability to enjoy life. The person's quality of life should not be used to make judgments about the value of that person's life.
(2) The proposed operation was a positive act and could not be classified as an omission.
(3) Since it was not certain that Mary was in pain, the operation was in Jodie's but not Mary's best interests (Walker LJ dissented from this and argued that the operation was in Mary's best interests).
(4) There was a conflict between Jodie's and Mary's best interests, welfare and right to life. There was, therefore, a conflict in the court's duty to give paramount consideration to the welfare of each twin. As such, the court had to choose the lesser of two evils and adopt the least detrimental course. This involved a balancing exercise.
(5) Although both twins had the same right to life, the value to Jodie in operating was far greater than the value to Mary in not operating. Jodie could be helped by medical treatment, but Mary was beyond help. Therefore, the proposed operation was the least detrimental alternative.
(6) Although the operation was the best course of action it must still be shown to be lawful. Because the benefit was to one person while the detriment fell on the other, the doctrine of double effect was not applicable. The operation would kill Mary and, unless justified, would be murder. However, Mary was putting such a strain on Jodie's vital organs that she was, in effect, killing her. The doctor's were justified in coming to J's defence. Thus, the operation was justified by a plea of 'quasi self-defence' in the exceptional circumstances.

Note

(1) It was also argued that the operation would be justified by necessity. Brooke LJ stated: 'According to Sir James Stephen, there are three necessary requirements for the application of the doctrine of necessity: (i) the act is needed to avoid inevitable and irreparable evil; (ii) no more should be done than is reasonably necessary for the purpose to be achieved; and (iii) the evil inflicted must not be disproportionate to the evil avoided.

Given that the principles of modern family law point irresistibly to the conclusion that the interests of Jodie must be preferred to the conflicting interests of Mary, I consider that all three of these requirements are satisfied in this case.'

(2) The balancing act to find the least detrimental course is only appropriate where the conflict is between two legal duties. It does not apply where one of the duties is a moral duty only.

(3) The court also considered that conjoined twins were two legal persons. Walker LJ stated: 'They have two brains and two nearly complete bodies, despite the grave defects in Mary's brain and her heart and lungs. There are cases of incomplete (or heteropagus) twinning in which a child is born with abnormalities which can be regarded as no more than a parasitic attachment. But it…could not be suggested that this case comes anywhere near that category.'

(4) The court held that 'intention' (Art 2 of the European Convention on Human Rights) should be given its ordinary meaning rather than the meaning of 'intention' in the criminal law (includes acts where death is foreseen as a virtually certain consequence of the act irrespective of the actor's desire or the purpose of the act: *R v Woollin* (1999) HL). As such, since the operation did not have the purpose of causing Mary's death, it would not be contrary to the HRA 1998.

(5) Ward LJ stated that the decision was restricted to 'unique circumstances'. The circumstances that must be satisfied for the decision to be used as an authority are 'that it must be impossible to preserve the life of X without bringing about the death of Y, that Y by his or her continued existence will inevitably bring about the death of X within a short period of time, and that X is capable of living an independent life but Y is incapable under any circumstances (including all forms of medical intervention) of viable independent existence'.

Think point

When there is conflict, who should determine the child's best interests?

4.6 Children and confidentiality

Children are entitled to confidentiality. For minors who do not possess *Gillick* competence, parents can determine when to consent to disclosure. The *Gillick* case has been interpreted as implying that a competent child is equally entitled to confidentiality. This is logical if one considers that one of Lord Fraser's justifications for allowing the minor to consent was that he (the doctor) cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice. This implies that she is entitled to the doctor's confidence otherwise he would not have to try and persuade her 'to allow him to inform the parents'.

The BMA (1993) states:

> The duty of confidentiality owed to a minor is as great as the duty owed to any other person.

It further states:

> …a doctor should try to persuade the patient to allow parents to be informed of the consultation, but should not override the patient's refusal to do so. In the BMA's view, even when the doctor considers the young person is too immature to consent to the treatment requested, confidentiality should still generally be maintained concerning the consultation.

Montgomery (1997) suggests this is in line with the law but points out that, because public policy provides the foundations for confidentiality, 'there is still scope for uncertainty'.

4.6.1 When a parent consents to disclosure of confidential information that is not in the child's best interests, the courts can prevent them from doing so

Section 8 of the Children Act 1989

Under s 8, the court may make a number of orders provided that:

> …doing so would be better for the child than making no order at all [s 1(5)].

The orders are listed under s 8(1) and include:

> …a 'prohibited steps order' means an order that no step which could be taken by a parent in meeting his parental responsibility for a child, and which is of a kind specified in the order, shall be taken by any person without the consent of the court;
>
> …a 'specific issue order' means an order giving directions for the purpose of determining a specific question which has arisen, or which may arise, in connection with any aspect of parental responsibility for a child.

Re Z (1995) CA

The mother of a handicapped child obtained an injunction *in rem,* to prevent the media from revealing the identity of the child or any school or other establishment in which she was residing, being educated or treated. The child began to receive treatment at a specialised foreign institution. A television company wanted to make a film about the work of the institute. The mother wanted to permit the filming in order to publicise the valuable work of the institution and thereby to enhance the child's welfare and self-esteem. She applied for the injunction to be discharged or varied to allow the filming. Her

application was turned down at first instance and the mother appealed, contending that the court should never override the reasonable decision of a responsible parent and that freedom of publication should prevail.

Held: appeal dismissed.

(1) In accordance with s 1(1)(a) of the Children Act 1989, the child's welfare was the court's paramount consideration and prevailed over the interest in the freedom of publication. The court may not exercise its power if freedom of publication was in the prevailing interest and the material was only indirectly referable to the child.
(2) The disclosure of confidential information relating to a child was an exercise of parental responsibility within the meaning of s 3(1)(b) of the 1989 Act which the court was empowered to restrain by means of a prohibited steps order under s 8 of the Act. The court could refuse to permit a parent's exercise of parental responsibility even though it was *bona fide* and reasonable if it was contrary to the child's best interests.
(3) In this instance, the child's welfare would be harmed by the publicity from a television programme.

4.6.2 The child's right to confidentiality mirrors the child's right to consent

Gillick v West Norfolk and Wisbech AHA (1986) HL

For the facts and decisions, see 4.2.1.

Specifically, Lord Fraser's five conditions must allow a right of confidence. See discussion above.

4.6.3 There is a statutory right to confidentiality

Section 4 of the Data Protection Act (DPA) 1998

(4) Subject to s 27(1), it shall be the duty of a data controller to comply with the data protection principles in relation to all personal data with respect to which he is the data controller.

Schedule 1, Part 1: The principles

(1) Personal data shall be processed fairly and lawfully and, in particular, shall not be processed unless:

(a) at least one of the conditions in Sched 2 is met; and
(b) in the case of sensitive personal data, at least one of the conditions in Sched 3 is also met.

Note

Medical records count as 'sensitive personal data'. The DPA 1998 covers both automatic and manual (paper) records.

Schedule 3 provides a long list of requirements of which one must be satisfied before the data can be processed. For more consideration of the requirements of Schedules 2 and 3, see Chapter 10.

Note

Children in Scotland are specifically provided for by the Act. Section 66(1) states: 'Where a question falls to be determined in Scotland as to the legal capacity of a person under the age of sixteen years to exercise any right conferred by any provision of this Act, that person shall be taken to have that capacity where he has a general understanding of what it means to exercise that right.' Section 66(2) provides that 'a person of 12 years of age or more shall be presumed to be of sufficient age and maturity to have such understanding'. The capacity of children in England will be governed by s 8(1) of the Family Law Reform Act 1969 and the principles laid down in *Gillick*.

4.7 Right of access to medical records

4.7.1 Competent children have a statutory right to access their medical records

Section 7 of the DPA 1998

For details, see 10.4.

4.7.2 Competent children may prevent the person with parental responsibility from having the right to access to their notes

The Data Protection (Subject Access Modification) (Health) Order 2000

(3) Where any person falling within paragraph (4) is enabled by or under any enactment or rule of law to make a request on behalf of a data subject and has made such a request, personal data to which this Order applies [health data] are exempt from s 7 [Data Protection Act 1998] in any case to the extent to which the application of that section would disclose information:

(a) provided by the data subject in the expectation that it would not be disclosed to the person making the request;

(b) obtained as a result of any examination or investigation to which the data subject consented in the expectation that the information would not be so disclosed; or
(c) which the data subject has expressly indicated should not be so disclosed,

provided that sub-paragraphs (a) and (b) shall not prevent disclosure where the data subject has expressly indicated that he no longer has the expectation referred to therein.

(4) A person falls within this paragraph if:

(a) except in relation to Scotland, the data subject is a child, and that person has parental responsibility for that data subject;
(b) in relation to Scotland, the data subject is a person under the age of sixteen, and that person has parental responsibilities for that data subject; or
(c) the data subject is incapable of managing his own affairs and that person has been appointed by a court to manage those affairs.

5 Refusal of Treatment

The right to refuse treatment follows naturally from the rules of consent. If medical treatment is only lawful—for competent adults—when it is done with consent, then a refusal to give consent will make medical treatment unlawful (see Chapter 2). The right to refuse treatment is thus based on the principle of autonomy and the right to bodily integrity. Respecting the individual's right to refuse treatment also respects his dignity and this is important both ethically and legally (Art 3 of the European Convention on Human Rights prohibits inhuman or degrading treatment). However, the right to give or refuse consent is not absolute. Ethically, a number of liberty limiting constraints operate when an individual's actions threaten to adversely affect other individuals. The most widely accepted of these is the 'harm theory' (Mill (1991)), which states that the only justification for restricting an individual's liberty is to prevent harm to others. Some commentators extend this to also prevent self-harm (Raz (1989)). The question for the law is whether and how these ethical constraints should be legally enforced?

5.1 A competent adult patient has the right to refuse medical treatment

5.1.1 This right exists even if it will result in the patient's death

Nancy B v Hotel-Dieu de Quebec (1992) Quebec Superior Court

Nancy B was a 25 year old woman suffering from Guillain-Barre syndrome. This incurable neurological disorder meant that she was paralysed and, since she was unable to breath without assistance, ventilator dependent. She was mentally competent and sought an injunction to prevent the hospital from continuing to treat her with artificial ventilation.

Held: the injunction was granted. The hospital must stop treatment with the ventilator. The right of the individual to refuse treatment is almost absolute being subject only to a corresponding right of others. The individual may not threaten the life or health of others.

Dufour J stated:

> The logical corollary of this doctrine of informed consent is that the patient generally has the right not to consent, that is, the right to refuse treatment and to ask that it cease where it has already been begun.

Note

Although this is a Canadian case, the same principle has been explicated by the House of Lords in *Airedale NHS Trust v Bland* (1993). Lord Goff stated: '…it is established that the principle of self-determination requires that respect must be given to the wishes of the patient, so that, if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so. To this extent, the principle of the sanctity of life must yield to the principle of self-determination.'

Think point

What is the sanctity of life principle?

5.1.2 The right to refuse treatment exists even if the patient is pregnant with a viable fetus

St Georges Healthcare NHS Trust v S; R v Collins and Others ex p S (1998) CA

S was a pregnant 28 year old veterinary nurse who, at 36 weeks of gestation, was diagnosed with pre-eclampsia severe enough to require hospital admission and an induction of labour. S was advised as to the potentially life threatening risks to her and her baby. It was accepted that she understood the risks but she rejected the advice because, as she later documented, 'I have always held very strong views with regard to medical and surgical treatments for myself, and particularly wish to allow nature to 'take its course' without intervention'. She was compulsorily detained for assessment under s 2 of the Mental Health Act (MHA) 1983, justified by a previous diagnosis of moderate depression, her own admission that she was probably depressed and her GP's statement that her 'mental state may be compromising her ability to make decisions'. An *ex parte* declaration that a non-consensual caesarean would be lawful was granted, the operation was performed and the baby safely delivered. S appealed.

Held: since S was competent, the non-consensual caesarean section was unlawful and a battery.

The Court of Appeal judgment stated:

While pregnancy increases the personal responsibilities of a woman, it does not diminish her entitlement to decide whether or not to undergo medical treatment. Although human, and protected by the law…an unborn child is not a separate person from its mother. Its need for medical assistance does not prevail over her rights. She is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it. Her right is not reduced or diminished merely because her decision to exercise it may appear morally repugnant.

Note

In *Re T (Adult: Refusal of Treatment)* (1992), Lord Donaldson MR stated: 'An adult patient who, like Miss T, 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 treatments being offered. The only possible qualification is a case in which the choice may lead to the death of a viable foetus. That is not the case and, if and when it arises, the court will be faced with a novel problem of considerable legal and ethical complexity.' This *dictum* was seized upon by Sir Stephen Brown P to justify a non-consensual caesarean in *Re S* (1992), in which the competent adult woman had refused the operation on religious grounds. That decision was heavily criticised (see 1994)) and was overruled by the Court of Appeal's judgment in *St George's Healthcare NHS Trust v S*. However, the flexibility of the test for competency may still allow judges to circumvent a refusal by finding the woman incompetent (see *Rochdale Healthcare (NHS) Trust v C* (1997), in which Johnson J overruled the consultant obstetrician's opinion that the woman was competent and argued: 'The patient was in the throes of labour with all that is involved in terms of pain and emotional stress… a patient who could, in those circumstances, speak in terms which seemed to accept the inevitability of her own death, was not a patient who was able properly to weigh up the consideration that arose so as to make any valid decision about anything of even the most trivial kind, surely still less one which involved her own life').

Think points

(1) What is the moral value of a fetus?
(2) Is this different to its legal value?
(3) What rights should the fetus have?
(4) What obligations should the mother have towards her fetus?
(5) Has the law achieved a justifiable balance?

5.1.3 Public policy might constrain the competent adult's right to refuse treatment

Secretary of State for the Home Department v Robb (1995)

An adult prisoner was refusing all nutrition. He was found to be competent. The Home Secretary sought a declaration that it would be lawful for those looking after the prisoner to abide by his refusal.

Held: the declaration was granted that an adult of sound mind and capacity had a specific right of self-determination which entitled him to refuse nutrition and hydration. That right was not diminished just because he was a detained prisoner.

Thorpe J considered four State interests that might override a competent adult's refusal of consent. These were detailed in the US case *Thor v Superior Court* (1993):

(1) preserving life;
(2) preventing suicide;
(3) maintaining the integrity of the medical profession;
(4) protecting innocent third parties.

None of these applied in the case before him.

Note

There will be very few circumstances when these might apply in the context of medical treatment. They do not apply under normal circumstances, nor do they apply when the life of a fetus is at risk. Regarding the third interest, Thorpe J stated: 'The third consideration of maintaining the integrity of the medical profession is one that I find hard to recognise as a distinct consideration.' Perhaps the main situation is in the justification of treating attempted suicides without their consent. This would not apply to the refusal of life saving treatment *(Nancy B)* or nutrition *(Robb)*.

5.1.4 The Doctrine of necessity cannot be used to override a competent adult's decision

F v West Berkshire HA (1989) HL

For the facts and decision, see 3.2.2 and 3.4.1.

Lord Goff stated:

> I wish to observe that officious intervention cannot be justified by the principle of necessity. So intervention cannot be justified…when it is contrary to the known wishes of the assisted person, to the extent that he is capable of rationally forming such a wish.

5.1.5 Competent patients may not be able to refuse basic hygiene care and pain relief

Law Commission Report No 231, *Mental Incapacity*, 1995, para 5.34

In the consultation paper we proposed that an advance directive should never be effective in refusing either pain relief or basic care. On consultation, there was general agreement to the proposition that a patient's right to self-determination could properly be limited by considerations based on public policy. (See, also, Law Commission Consultation Paper No 129,1993, para 3.25.)

Note

Although there is no case law on the issue, the opinion of the Law Commission and some academic commentators is that the refusal of basic care could be overridden on the public policy ground that it would be in the interests of professionals and other patients who would otherwise be affected by the refusal.

Think point

How do you think this argument might be affected by the Human Rights Act 1998?

5.2 Patients detained under the Mental Health Act (MHA) 1983 may be treated against their will if the treatment is for mental disorder

Section 63 of the MHA 1983

See 9.3.1.

5.2.1 Medical treatment includes 'nursing, and also includes care, habilitation and rehabilitation under medical supervision (s 145(1) of the MHA 1983) and this may be given a broad interpretation to include ancillary treatment

B v Croydon HA (1994) CA

For the facts and decision, see 9.3.2.

5.3 Incompetent patients have no legal right to refuse consent

This naturally follows because incompetent patients are unable to give a legally valid consent. However, it is important to distinguish between patients with psychiatric disorders who may still be competent to refuse consent *(Re C (Adult: Refusal of Treatment)* (1994)) and those patients who lack capacity (who may or may not have a psychiatric disorder). When an incompetent patient does refuse treatment, the healthcare professional may have a duty to treat the patient against their will. The patient's refusal is an important factor that will have to be added to the benefits/harm equation. If treatment is in the best interests of the incompetent patient, then treatment may be given despite the wishes of the patient (see Chapter 3).

F v West Berkshire HA (1989) HL

For the facts and decision, see 3.2.2 and 3.4.1.

5.4 A competent minor's refusal to give consent may be overridden by the court or any person with parental responsibility

Re R (A Minor) (Wardship: Consent to Treatment) (1991) CA

For the facts and decision, see 4.2.3.

Note

This also applies to children over the age of 16 who have a statutory right to consent under s 8 of the Family Law Reform Act 1969. In *Re W (A Minor) (Medical Treatment)* (1992) CA, which concerned the refusal of consent by a 16 year old girl with anorexia, the Court of Appeal argued that s 8 gave the child the right to consent, but did not take that right away from the parents. Lord Donaldson MR regretted his 'key holder' analogy and argued instead: 'I now prefer the analogy of the legal "flak jacket" which protects the doctor from claims by the litigious whether he acquires it from his patient who may be a minor over the age of 16, or a "*Gillick* competent" child under that age or from another person having parental responsibilities which include the right to consent to treatment of the minor…the doctor only needs one [flak jacket].' Lord Donaldson MR concluded that: 'No minor of whatever age has power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for

the minor and *a fortiori* a consent by the court. Nevertheless, such a refusal is a very important consideration in making clinical judgments and for parents and the court in deciding whether themselves to give consent. Its importance increases with the age and maturity of the minor.' See, also, *R v M* (1999).

Think point

What are the arguments for and against allowing an individual to give consent but not allowing them the right to refuse treatment?

6 Death and Euthanasia

Euthanasia refers to the practice of ending another person's life with the intention of ending their suffering. It is sometimes described as the practice of bringing about a 'good' or 'quiet' death. It can be classified as involuntary (against the wishes of a competent person); voluntary (with the wishes of a competent person); and non-voluntary (where the individual is incompetent). These categories may be sub-divided as active (a positive act that causes the death) or passive (an omission or failure to act).

Think point

Why should there be a distinction between an act and an omission?

6.1 Active euthanasia

6.1.1 Active euthanasia is murder

R v Cox (1992)

Dr Cox was a consultant physician. One of his patients was a 70 year old woman suffering from severe and extremely painful rheumatoid arthritis. It was uncertain how much longer she would have lived for but she could have died at any time. The pain she suffered was not controllable with analgesic drugs. After she asked Dr Cox to put her out of her misery, he injected her with a lethal dose of potassium chloride. Because she could have died at any time and hence pre-empted the effect of the potassium chloride, Dr Cox was charged only with attempted murder.

Held: Dr Cox was found guilty of attempted murder by the jury.

In directing the jury, Ogden J stated:

> …if it is proved that Dr Cox injected Lillian Boy es with potassium chloride in circumstances which make you sure that by that act he intended to kill her, then he is guilty of the offence of attempted murder…
> You must understand, members of the jury, that in this highly emotional situation, neither the express wishes of the patient nor of her loving and devoted family can affect the position.

Note

In *Airedale NHS Trust v Bland,* Lord Goff stated: 'But it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be… So to act is to cross the Rubicon which runs between, on the one hand, the care of the living patient and, on the other hand, euthanasia—actively causing his death to avoid or to end his suffering. Euthanasia is not lawful at common law.'

6.1.2 Where death is not Intended', a positive act (for a lawful purpose) that also hastens the death of the patient is lawful

R v Bodkin Adams (1957)

One of the accused's patients was an elderly patient who had suffered a stroke. Dr Bodkin Adams was a substantial beneficiary of the victim's will. He increased the dose of his patient's opiate analgesic. The victim subsequently died and Dr Bodkin Adams was charged with murder.

Held: not guilty of murder.

In directing the jury, Devlin J stated:

> If the first purpose of medicine, the restoration of health, can no longer be achieved, there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten life.

Note

The rationale behind this decision is the doctrine of double effect. The doctrine receives both academic support and criticism, but it has been accepted as a valid legal principle. Thus, in *R v Cox,* Ogden J explains: 'There can be no doubt that the use of drugs to reduce pain and suffering will often be fully justified notwithstanding that it will, in fact, hasten the moment of death. What can never be lawful is the use of drugs with the purpose of hastening the moment of death.' Montgomery (1997) suggests that three conditions must be satisfied: (1) the patient must be terminally ill; (2) the drugs given must be considered appropriate treatment by a responsible body of physicians; and (3) the motive must be to relieve suffering and not to shorten life.

6.2 Passive euthanasia

6.2.1 It is lawful to accede to a competent patient's wishes not to be treated

Re T (Adult: Refusal of Medical Treatment) (1992) CA

For the facts and decision, see 2.3.1.

Lord Donaldson MR stated:

> An adult patient who, like Miss T, 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 treatments being offered.

Nancy B v Hotel-Dieu de Quebec (1992) Quebec Superior Court

For the facts and decisions, see 5.1.1.

Note

The legality of passive voluntary euthanasia is the corollary of the competent patient's right to refuse treatment. Once the patient has refused treatment then, providing the patient is competent, the doctor is relieved of his duty to provide the treatment refused.

6.2.2 It is lawful not to treat an incompetent patient providing it is not contrary to the patient's best interests

Re J (A Minor) (Wardship: Medical Treatment) (1990) CA

For the facts and decision, see 4.3.2.

Lord Donaldson MR stated:

> The issue here is whether it would be in the best interests of the child to put him on a mechanical ventilator and subject him to all the associated processes of intensive care, if at some future time he could not continue breathing unaided … The basis of the doctor's recommendations…was that mechanical ventilation is itself an invasive procedure which, together with its essential accompaniments…would cause the child distress. Furthermore, the procedures involve taking active measures which carry their own hazards, not only to life but in terms of causing greater brain damage. This had to be balanced against what could possibly be achieved by the adoption of such active treatment.

Note

Although the judiciary generally refer to acting in the patient's best interests, it is clear that the test for withholding or withdrawing treatment is more accurately described as not being contrary to the best interests of the incompetent patient. Thus, in *Airedale NHS Trust v Bland*, Lord Mustill stated: 'Unlike the conscious patient he does not know what is happening to his body, and cannot be affronted by it… The distressing truth which must not be shirked is that the proposed conduct is not in the best interest of Anthony Bland, for he has no best interests of any kind… Although the termination of his life is not in the best interests of Anthony Bland, his best interests in being kept alive have also disappeared, taking with them the justification for the non-consensual regime and the correlative duty to keep it in being.'

6.2.3 Treatment may be withheld if the only life it could provide would be 'intolerable'

Re R (Adult: Medical Treatment) (1996)

R was a 23 year old man with severe mental and physical disabilities, who was existing in what was described as a 'low awareness state'. He had suffered five previous life threatening episodes requiring hospital treatment. The trust sought a declaration that it would be lawful to withhold cardio-pulmonary resuscitation. In the event of a life threatening infection the trust also wanted to withhold antibiotics, but only if R's GP and one of his parents agreed.

Held: the declaration was granted in accordance with the experts' recommendations.

Sir Stephen Brown P quoted with approval Taylor LJ, who stated:

> I consider the correct approach is for the court to judge the quality of life the child would have to endure if given the treatment, and decide whether in all the circumstances such a life would be so afflicted as to be intolerable to that child. *(Re J (A Minor) (Wardship: Medical Treatment)* (1990) CA.)

6.2.4 Artificial feeding may be withdrawn where there was no prospect of meaningful life even where the patient does not fulfil the guidelines for diagnosis of persistent vegetative state

Re D (Medical Treatment) (1998)

D was a young woman, totally dependent on artificial nutrition and hydration, who showed no signs of awareness. Her mother and all the expert

witnesses agreed that it was in her best interests for the feeding and hydration to be withdrawn. Three consultant neurologists diagnosed that she was in an irreversible vegetative state. However, one of the paragraphs of the Royal College of Physicians' guidelines was not satisfied. The hospital applied for a declaration that it would be lawful to withdraw feeding and hydration. The application was opposed by the Official Solicitor on the grounds that she did not satisfy the guidelines and it could, therefore, not be said that it was futile to keep her alive.

Held: declaration granted. Where there was no awareness and no meaningful life and 'the patient was suffering a living death' it was not in her best interests to keep her alive, regardless of whether she satisfied all the guidelines.

Sir Stephen Brown P drew attention to the present procedure that doctors are always advised to seek the court's declaration and stated:

> The court recognises that no declaration to permit or to sanction the taking of so extreme a step could possibly be granted where there was any real possibility of meaningful life continuing to exist… In this case…there is no evidence of any meaningful life whatsoever.

Note

This case extends the guidelines laid down in the Official Solicitor's Practice Note (see below) from patients in permanent vegetative state to those with no real possibility of meaningful life. However, the patient was diagnosed as being in the vegetative state and therefore this extension may not apply to patients without a 'meaningful life' who are not in the vegetative state.

6.2.5 Withdrawal of treatment is equivalent to an omission rather than a positive act

Airedale NHS Trust v Bland (1993) HL

For the facts and decision, see 3.3.1.

Lord Goff stated:

> I agree that the doctor's conduct in discontinuing life support can properly be categorised as an omission. It is true that it may be difficult to describe what the doctor actually does as an omission, for example, where he takes some positive step to bring the life support to an end. But discontinuation of life support is, for present purposes, no different from not initiating life support in the first place. In each case, the doctor is simply allowing his patient to die in the sense that he is desisting from taking a step which might, in certain circumstances, prevent his patient from dying

as a result of his pre-existing condition, and as a matter of general principle, an omission such as this will not be unlawful unless it constitutes a breach of duty to the patient.

Note

This does not apply to oral feeding and hydration, but solely to feeding and hydration by naso-gastric, intravenous or percutaneous routes (for example, a feeding tube inserted directly into the stomach).

Think point

Do you agree that withdrawal of treatment is an omission, and does it matter in the context of healthcare?

6.2.6 Artificial nutrition and hydration are forms of medical treatment that may be withheld or withdrawn where it is not contrary to the patient's best interests

Airedale NHS Trust v Bland (1993) HL

For the facts and decision, see 3.3.1.

Lord Keith stated:

> I am of the opinion that regard should be had to the whole regime, including the artificial feeding, which at present keeps Anthony Bland alive. That regime amounts to medical treatment and care, and it is incorrect to direct attention to the fact that nourishment is being provided. In any event, the administration of nourishment by the means adopted, involves the application of a medical technique.

6.2.7 It is good practice to seek the court's approval before withdrawing artificial feeding and nutrition from patients in the vegetative state

Official Solicitor to the Supreme Court Practice Note: *Vegetative State* [1996] 2 FLR 375

(1) The termination of artificial feeding and hydration for patients in the vegetative state will, in virtually all cases, require the prior sanction of a High Court judge.
(2) The diagnosis should be made in accordance with the most up to date, generally accepted guidelines for the medical profession… Such a diagnosis may not reasonably be made until the patient has been in a continuing vegetative state following a head injury for more than 12 months or, following other causes of brain damage, for more than six months.

Note

See, also, Lord Goff in *Airedale NHS Trust v Bland*, who approved of Sir Thomas Bingham MR's view in the Court of Appeal hearing of *Bland* that, until a body of experience and practice had been built up, it would be wise to present such decisions for the court's approval. This would protect both patient and doctor and reassure the patient's family and the public at large.

Think point

What is the function of the court's declaratory order? What implication does this have for a physician who withdraws treatment without seeking such an order?

6.2.8 When a decision as to continue artificial nutrition has to be taken urgently or as an emergency it may not be necessary to follow the official guidelines

Frenchay Healthcare NHS Trust v S (1994) CA

S suffered severe brain damage following a drug overdose. He was being fed by a gastrostomy inserted through his stomach wall. The tube became dislodged and there was no prospect of replacing it without a surgical operation. The consultant in charge of the patient felt that it was in S's best interests to be allowed to die. The hospital applied for an urgent declaration that it would be lawful not to replace the feeding tube. The declaration was granted. The Official Solicitor appealed because: (i) he had not been given the opportunity to investigate the matter and ensure all the relevant material was available; and (ii) the judge had attached too much importance to the medical opinion of S's best interests.

Held: appeal dismissed:

> Although the court had the ultimate power and duty to review the medical decision in the light of all the facts and should not necessarily accept medical opinion as to what was in the patient's best interests…the court should be reluctant to place those treating the patient in a position of having to carry out treatment which they considered to be contrary to the patient's best interests, unless the court had real doubt about the reliability, *bona fides* or correctness of the medical opinion.

Per curia:

> Where a hospital seeks to discontinue treatment of a patient in a persistent vegetative state, as a general rule the hospital should apply to the court for and obtain a declaration that it was proper to do so, and such an application should be preceded by a full investigation with an opportunity for the Official Solicitor …to explore the situation fully, to obtain independent medical opinions…and to

ensure that all the proper material was before the court. Nevertheless, emergency situations will arise in which an application to the court is not possible, or where, although an application to the court is possible, it will not be possible to present the application in the same leisurely way as in the case where there is no pressure of time.

6.3 Assisted suicide

6.3.1 It is unlawful to assist another person to commit suicide

Section 2 of the Suicide Act 1961

(1) A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding 14 years.

6.3.2 The offence requires that the accused had knowledge of and encouraged the suicide attempt

Attorney General v Able (1984)

The Voluntary Euthanasia Society (VES) published a booklet which disapproved of hasty suicide decisions but also provided descriptions of how to achieve successful 'self-deliverance'. The Attorney General, who had evidence that the book was associated with 15 suicides, sought a declaration that the book was unlawful under s 2 of the 1961 Act.

Held: the book was not necessarily unlawful. A successful prosecution would have to show:

(1) the accused knew that suicide was being considered;
(2) the accused approved of or assented to the decision; and
(3) the accused encouraged the attempt.

6.3.3 It is unlawful to attempt to assist another to commit suicide

R v McShane (1977) CA

The appellant had been left money that was held in trust. The trust provided that her mother should receive an income from the estate for life. Her mother was an elderly infirm woman who had previously talked of committing suicide. The appellant, on a number of occasions, left fatal doses of pills with

her mother. On the last occasion she was heard to say 'Whisky with barbiturates is fatal'. She was convicted of an attempt to counsel or procure her mother's suicide. She appealed on the grounds that this was not an offence in law.

Held: appeal dismissed. An attempt to commit an offence (statute or common law) is a common law offence, even where the crime 'is itself of the nature of an attempt'.

6.4 Death

6.4.1 Legal death is the same as medical death

Re A (1992)

A was a 19 month old child admitted to hospital with a head injury and absent heartbeat which his mother claimed arose from him having fallen from a table. The suspicion was of a non-accidental injury and A's left leg was still splinted from a previous admission. A few days following his resuscitation, A was diagnosed as brain-stem dead. The child had been the subject of an emergency protection order which gave parental responsibility to the local authority. The parents subsequently applied and were granted an order that stated, 'No person with parental responsibility, namely the parents and the local authority, shall give consent to the switching off of a life support machine in respect of A, without the consent of these others with parental responsibility and after consultation with the guardian *ad litem*'. An application was made for a declaratory order that it would be lawful to disconnect A from the ventilator.

Held: declaration granted.

Johnson J accepted the doctor's submission that A was brain dead according to the recommendations of the Royal College of Physicians, the Royal College of Surgeons and the British Paediatric Association. He stated:

> I hold that I have the jurisdiction to make a declaration that A is now dead for all legal, as well as medical, purposes, and also to make a declaration that should the consultant or other medical consultants at Guy's Hospital consider it appropriate to disconnect A from the ventilator, in so doing they would not be acting contrary to law.

Note

In *R v Malcherek* (1981) CA, Lord Lane LCJ stated: 'Where a medical practitioner, using generally accepted methods, came

to the conclusion that the patient was, for all practical purposes, dead, and that such vital functions as remained were being maintained solely by mechanical means, and accordingly discontinued treatment, that did not break the chain of causation.'

7 Organ Transplantation

7.1 Live organ donation

Organ transplantation using organs from live donors is governed partly by the common law and partly by statute. The common law requires that both parties consent, and clearly the consent of the donor will be invalid if donation of the organ would result in death. Where the donor lacks the capacity to give a valid consent, it may still be possible for donation to be lawful.

Note

The Human Organ Transplants Act 1989 and regulations only apply to non-regenerative organs (s 7(2)). Regenerative organs, such as blood or bone marrow, fall under the common law.

7.1.1 It will only be lawful to accept organ donation from an incompetent adult patient if the donation is in their best interests

Re Y (Adult Patient) (Transplant: Bone Marrow) (1996)

Y, a 25 year old woman with severe mental and physical disabilities, had an older sister who required a bone marrow transplant. A declaration was sought to determine if non-consensual blood tests and bone marrow extraction would be lawful.

Held: declaratory order granted, as it would be in Y's best interests to assist her sister.

Connell J stated:

> The test to be applied in a case such as this is to ask whether the evidence shows that it is in the best interests of the defendant for such procedures to take place. The fact that such a process would obviously benefit the plaintiff is not relevant unless, as a result of the defendant helping the plaintiff in that way, the best interests of the defendant are served.

He argued that the donation would be beneficial because the death of her sister would have a detrimental effect on Y's mother. By helping to preserve

her sister's life, Y would improve her relationship with her mother and her sister. A successful transplantation would also allow Y's mother more time to spend with Y. This visiting time would be adversely affected if her sister's health deteriorated.

Note

Bone marrow is regenerative. It might be much harder to demonstrate that donation is in the donor's best interests for non-regenerative organs. However, in the US, the Kentucky Court of Appeal sanctioned a kidney transplant from an incompetent adult to his brother: *Strunk v Strunk* (1969).

7.1.2 Even where a minor is *Gillick* competent, the parent's consent should be sought

Re W (A Minor) (Medical Treatment) (1992) CA

W was a 17 year old girl suffering from anorexia. She was refusing consent to all treatment, despite her deteriorating health. An order was sought that it would be lawful to treat her non-consensually in a specialist unit.

Held: order granted. The anorexia destroyed her ability to make an informed choice.

Lord Donaldson MR stated *(obiter):*

> I doubt whether blood donation will create any problem as a '*Gillick* competent' minor of any age would be able to give consent under the common law.
>
> Organ transplants are quite different and, as a matter of law, doctors would have to secure the consent of someone with the right to consent on behalf of a donor under the age of 18 or, if they relied upon the consent of the minor himself or herself, be satisfied that the minor was '*Gillick* competent' in the context of so serious a procedure which would not benefit the minor. This would be a highly improbable conclusion. But this is only to look at the question as a matter of law. Medical ethics also enter into the question. The doctor has a professional duty to act in the best interests of his patient and to advise accordingly. It is inconceivable that he should proceed in reliance solely upon the consent of an under age patient, however '*Gillick* competent', in the absence of supporting parental consent…[he] may well be advised to apply to the court for guidance.

Note:

Lord Donaldson MR is not suggesting that a '*Gillick* competent' minor could never give a valid consent. However, he is advising that at the least, the doctor should also seek the parent's consent. The safest course would be for the doctor to seek a declaratory order. Clearly, Lord

Donaldson MR does believe that parental consent may be valid. For this to be so, the parents would need to consider both the benefits and detriments of the donation and make a 'reasonable' decision.

Think point

What factors might be relevant when considering whether a minor should donate an organ?

7.1.3 Live organ donation is subject to restrictions unless the donor and recipient are genetically related

Section 2 of the Human Organ Transplants Act 1989

(1) Subject to sub-section (3) below, a person is guilty of an offence if in Great Britain he—

(a) removes from a living person an organ intended to be transplanted into another person; or
(b) transplants an organ removed from a living person into another person;
unless the person into whom the organ is to be or, as the case may be, is transplanted is genetically related to the person from whom the organ is removed.

(2) For the purposes of this section a person is genetically related to—

(a) his natural parents and children;
(b) his brothers and sisters of the whole or half blood;
(c) the brothers and sisters of the whole or half blood of either of his natural parents; and
(d) the natural children of his brothers and sisters of the whole or half blood or of the brothers and sisters of the whole or half blood of either of his natural parents…

Note

These relationships must be established by testing (including DNA testing) by a tester approved by the Secretary of State: The Human Organ Transplants (Establishment of Relationship) Regulations 1998.

7.1.4 Regulation of non-related live organ donation

Under the Human Organ Transplants (Unrelated Persons) Regulations 1989, authority to regulate unrelated donation is vested in the Unrelated Live Transplant Regulatory Authority (ULTRA).

Regulation 3 of the Human Organ Transplants (Unrelated Persons) Regulations 1989

(1) The prohibition in s 2(1) of the Act (restriction on transplants between persons not genetically related) shall not apply in cases where a registered medical practitioner has caused the matter to be referred to the Authority and where the Authority is satisfied—

(a) that no payment has been, or is to be, made in contravention of s 1 of the Act;
(b) that the registered medical practitioner who has caused the matter to be referred to the Authority has clinical responsibility for the donor; and
(c) except in a case where the primary purpose of removal of an organ from a donor is the medical treatment of that donor, that the conditions specified in paragraph (2) of this regulation are satisfied.

(2) The conditions referred to in paragraph (1)(c) of this regulation are—

(a) that a registered medical practitioner has given the donor an explanation of the nature of the medical procedure for, and the risk involved in, the removal of the organ in question;
(b) that the donor understands the nature of the medical procedure and the risks, as explained by the registered medical practitioner, and consents to the removal of the organ in question;
(c) that the donor's consent to the removal of the organ in question, was not obtained by coercion or the offer of an inducement;
(d) that the donor understands that he is entitled to withdraw his consent if he wishes, but has not done so;
(e) that the donor and the recipient have both been interviewed by a person who appears to the Authority to have been suitably qualified to conduct such interviews and who has reported to the Authority…

Note

These regulations raise the standard of consent required from the common law standard of disclosure to one of understanding. Also, because of the requirement for understanding, an incompetent person may not be an unrelated live donor.

7.2 Commercial dealings in non-regenerative organs

7.2.1 Commercial dealings are prohibited for both live and cadaver donations

Section 1 of the Human Organ Transplants Act 1989

(1) A person is guilty of an offence if in Great Britain he—

(a) makes or receives any payment for the supply of, or for an offer to supply, an organ which has been or is to be removed from a dead or living person and is to be transplanted into another person whether in Great Britain or elsewhere;
(b) seeks to find a person willing to supply for payment such an organ as is mentioned in paragraph (a) above, or offers to supply such an organ for payment;
(c) initiates or negotiates any arrangement involving the making of any payment for the supply of, or for an offer to supply, such an organ; or
(d) takes part in the management or control of a body of persons, corporate or unincorporated, whose activities consist of or include the initiation or negotiation of such arrangement.

Note

Sub-section (2) prohibits advertising in relation to commercial dealings for organs. Sub-section (3)(a) allows for reimbursement of the cost of removing, transporting or preserving an organ and (3)(b) allows for reasonable expenses and loss of earnings incurred by the donor.

Think point

Why ban commercial dealings in non-regenerative organs? Is a commercial ban morally justifiable?

7.3 Cadaver organ transplantation

Cadaver organ donation is regulated by the Human Tissue Act 1961. There are no sanctions contained within the Act for breaching its requirements. In *R v Lennox Wright* (1973), the accused was charged with the common law offence of disobedience of a statute. However, in *R v Horseferry Road Justices ex p IBA* (1986), the Court of Appeal ruled that contravening a statute would not be a criminal offence, unless the statute makes an express provision to cover that eventuality.

7.3.1 A person is dead if their brainstem function is irreversibly lost—brainstem death

Re A (1992)

For the facts and decision, see 6.4.1.

Johnson J accepted the guidelines for the definition of death laid down by the Royal College of Surgeons, the Royal College of Physicians and a working party of the British Paediatric Association. See (1976) 2 BMJ 1187.

Think point

Why is a definition of death based on heartbeat or breathing inadequate?

7.3.2 A person can request the use of his body or body parts after his death

Section 1 of the Human Tissue Act 1961 (as amended)

(1) If any person, either in writing at any time or orally in the presence of two or more witnesses during his last illness, has expressed a request that his body or any specified part of his body be used after his death for therapeutic purposes or for purposes of medical education or research, the person lawfully in possession of his body after his death may, unless he has reason to believe that the request was subsequently withdrawn, authorise the removal from the body of any part or, as the case may be, the specified part, for use in accordance with the request.

Note

(1) If a person dies in hospital, it is the hospital management who would be 'lawfully in possession'.
(2) The person making the request does not need to be competent.
(3) There is no minimum age set but it has been suggested that analogy may be drawn with the Family Law Reform Act 1969, which allows 16 year olds to consent to medical treatment (Dickens (1998)).
(4) There is no obligation to use the body or body parts.
(5) Legally, the relatives have no right to veto the deceased's expressed wish. However, in practice, doctors will usually ask the next of kin for permission. A Department of Health circular stated: 'If a patient carries a signed donor card or has otherwise recorded his or her wishes, for example, by inclusion in the NHS Donor Register, there is no legal requirement to establish lack of objection on the part of the relatives, although it is good practice to take account of the views of close relatives' (DoH, HSC 1998/035, 8.2).

Think point

What is the legal status of a request that places immoral conditions on the request?

7.3.3 If the deceased has made no prior request, then the body parts may be removed providing there is no objection from the deceased or his relatives

Section 1 of the Human Tissue Act 1961 (as amended)

(2) Without prejudice to the foregoing sub-section, the person lawfully in possession of the body of a deceased person may authorise the removal of any part from the body for use for the said purposes if, having made such reasonable enquiry as may be practicable, he has no reason to believe—

(a) that the deceased had expressed an objection to his body being so dealt with after his death, and had not withdrawn it; or
(b) that the surviving spouse, or any surviving relative of the deceased, objects to the body being so dealt with.

Note

(1) This sub-section requires the hospital to make 'reasonable enquiry'. While any relative's objection may theoretically veto the use of the deceased's body parts, a 'reasonable enquiry' would probably only include those relatives known to the hospital (Montgomery (1997)). The DoH suggest that: 'In most instances, it will be sufficient to discuss the matter with any one relative who has been in close contact with the deceased, determining whether there is reason to believe that any other relative would be likely to object. There is no need to establish a lack of objection from all the relatives before authorising the removal of organs' (DoH, HSC 1998/035,8.8, italics added). There may be circumstances, however, when the DoH's view is not reasonable and it should only be used as a guide. What is reasonable will vary from case to case.
(2) The *Report of the Royal Liverpool Children's Inquiry* (2001) which investigated the organ retention scandal stated: 'While the wording of the Human Tissue Act 1961 differs from the concept of informed consent, in practical terms there had to be informed consent for the next of kin at least, for there to have been compliance with the Act in the overwhelming majority of cases.' The Report further stated that: 'Comprehensive information is required to obtain a valid consent. Patients must be informed of the identity of each organ to be retained and the purpose for which it is to be used.'

(3) The *Report of the Royal Liverpool Children's Inquiry* (2001) made the following recommendations in relation to the Human Tissue Act 1961:

- instruction of the medical profession about the provisions of the Act;
- the Act should be amended to require informed consent, but only from the 'next of kin' rather than 'any surviving relative';
- the public should be educated as to the need for post mortems and access to organs;
- the medical profession should be trained in how to obtain fully informed consent;
- the Act should be amended to impose a criminal penalty for a breach of its terms;
- professional guidelines relating to the obtaining of informed consent should be drafted with appropriate disciplinary sanctions for those who breach them;
- a financial remedy should be made available where a breach of the Act also breaches the HRA 1998.

Think point

Is the system under the Human Tissue Act 1961 an 'opt out' or 'opt in' system? Would the recommendations of the report, if implemented, change the nature of the system?

7.3.4 Organs should not be accepted with conditions attached to the donation restricting the use of the organ

Following the revelation, in July 1999, that the UK Transplant Support Service Authority (UKTSSA) had accepted an organ with racist preconditions, the government set up a panel to consider the lawfulness and desirability of conditional donation (*An Investigation into Conditional Organ Donation*, 2000, www.doh.gov.uk/pub/docs/doh/organdonation.pdf). The report concluded that the Human Tissue Act 1961 'does not envisage conditional agreement'. Racist pre-conditions would breach s 20(1) and s 31(1) of the Race Relations Act 1976 and would be unlawful. Organs should not be accepted with conditions relating to the recipient, but if an organ is accepted by mistake, then the conditions may be disregarded and the organ used for the most suitable recipient (para 5.3(iii)). (For a discussion of racist preconditions, see Maclean (1999).)

Note

(1) The UKTSSA is a special Health Authority established in 1991. Its functions are 'assisting in, and facilitating or promoting, the

provision of a service for the transplantation of organs' (reg 2(1) of the the United Kingdom Transplant Support Service Authority Regulations 1991).

(2) It is arguable that since the Human Tissue Act 1961 is silent on the issue, it would not be unlawful to accept an organ donation with attached conditions, providing those conditions are lawful and not contrary to public policy. It might seem odd that a live donation could be restricted to a relative, but that a post mortem donation could not be. However, the panel's report suggests that any condition attached to post mortem donation may be against public policy. Since there is no obligation to accept a donation, it is likely in practice that no organs will be accepted if conditions are attached.

7.4 Post mortems and organ retention

7.4.1 The coroner may require a post mortem examination

Section 19 of the Coroners Act 1988

(1) Where a coroner is informed that the body of a person is lying within his district and there is reasonable cause to suspect that the person has died a sudden death of which the cause is unknown, the coroner may, if he is of the opinion that a post mortem examination may prove an inquest to be unnecessary—

(a) direct any legally qualified medical practitioner whom, if an inquest were held, he would be entitled to summon as a medical witness under section 21 below; or
(b) request any other legally qualified medical practitioner,

to make a post mortem examination of the body and to report the result of the examination to the coroner in writing.

Section 20 of the Coroners Act 1998

(1) …the coroner may, at any time after he has decided to hold an inquest—

(a) request any legally qualified medical practitioner to make a post mortem examination of the body or a special examination of the body or both such examinations; or
(b) request any person whom he considers to possess special qualifications for conducting a special examination of the body to make such an examination.

Section 21 of the Coroners Act 1998

(4) If, in the case of an inquest with a jury, a majority of the jury are of the opinion that the cause of death had not been satisfactorily explained by the evidence of the medical practitioner or of other witnesses brought before them, they may in writing require the coroner—

(b) to direct a post mortem examination of the deceased to be made by a practitioner summoned under this sub-section, whether or not such an examination has been previously made.

Note

(1) Other officials may also authorise post mortem examinations: see reg 12(5) of the Cremation Regulations 1930.
(2) The rules governing coroners' post mortems are contained within the Coroners Rules 1984. Rule 6 governs the choice of medical practitioner to perform the post mortem and r 7 requires the coroner to notify various parties.

7.4.2 Hospital post mortems are governed by the Human Tissue Act 1961

Section 2 of the Human Tissue Act 1961

(2) No post mortem shall be carried out otherwise than by or in accordance with the instructions of a fully registered medical practitioner, and no post mortem examination which is not directed or requested by the coroner or any other competent legal authority shall be carried out without the authority of the person lawfully in possession of the body; and sub-sections (2), (5), (6) and (7) of s 1 of this Act shall, with the necessary modification, apply with respect to the giving of that authority.

Note

(1) The caveat that s 1(2) applies to this section means that a reasonable enquiry must be made to determine whether the relatives or the deceased (in his lifetime) object(ed) to a post mortem.
(2) in response to the national scandal that erupted following the revelation that hospitals were retaining body parts without the knowledge of the relatives, the Department of Health has published interim guidance which requires a designated individual within each Hospital Trust to be responsible for supporting and informing the deceased's relatives when a post mortem request is made, whether by a hospital doctor or the Coroner. This person must obtain 'consent' to post mortem examination through a signed form which provides clear written information about:

(a) what the examination entails;
(b) which organs and tissues may be retained and why;
(c) how this might impact on the funeral arrangements and whether archiving for research or legal reasons is concerned.

('Consent' in this context reflects its everyday usage and does not import any legal meaning or implication.) The *Report of the Royal Liverpool Children's Inquiry* (2001) has subsequently proposed a detailed and comprehensive consent form to be completed when requesting a post mortem or organ donation.

7.4.3 Retention of body parts

There are a number of circumstances in which body parts may be lawfully retained. The Human Tissue Act 1961 allows organ retention for 'therapeutic purposes or for purposes of medical education or research' (s 1(1)). This power has the same constraints as the power for post mortem organ donation, that is, that the person in lawful possession is unaware—following reasonable enquiry—of any objection made by the deceased or his relatives. The Anatomy Act 1984 makes similar provisions (s 4) regarding the retention of body parts for teaching, studying, or researching into morphology (s 1). Retention is also lawful following a post mortem. Under r 9 of the Coroners Rules 1984, the coroner may direct the 'preservation of material which in his opinion bears upon the cause of death for such a period as the coroner sees fit'. For a post mortem under the Human Tissue Act 1961, it is probably lawful to retain tissue providing the purpose of retaining the tissue can be implied into the authorisation obtained for the post mortem. The forms recommended by the DoH as part of their interim guidelines (see above) require that a proposed retention be made explicit before authorisation is sought. A potential *lacuna* is where the tissue has been removed for a purpose that has since become frustrated or exhausted and the tissue is then put to some unauthorised use. Arguably, this is currently lawful providing the organ is used for some recognised medical use (see Maclean (2000)).

7.5 Ownership of body parts

Although English law does not traditionally allow a right of property in a corpse (*Williams v Williams* (1882)), there are circumstances in which rights in body parts may be claimed. Thus, it is possible to convict someone for theft of urine or blood (*R v Welsh* (1974); *R v Rothery* (1976)). There are also a number of statutory provisions (see above) that allow rights of possession in corpses and body parts (see, also, s 25 of the National Health Service Act 1977, which states that 'where the Secretary of State has acquired: (a) supplies of blood; or (b) any

part of a human body;…he may arrange to make such supplies or that part available…to any person').

7.5.1 Once a body part has been lawfully altered in character, the possessor gains the right to retain possession

R v Kelly (1998) CA

A junior technician who worked at the Royal College of Surgeons removed some body parts. The parts were needed by an artist who wished to use them as moulds for his work. The defendants denied a charge of theft on the grounds that there was no property in a corpse.

Held: the defendants were guilty of theft. The Court of Appeal stated that: '…parts of a corpse are capable of being property…if they have acquired different attributes by virtue of the application of skill, such as dissection or preservation techniques, for exhibition or teaching purposes.'

Note

See, also, *Doodeward v Spence* (1908). In *Moore v Regents of the University of California* (1990), the defendants had patented a cell line developed from cells taken from the patient's excised spleen. The value of therapies developed from this cell line were in excess of $3 bn. The plaintiff claimed, amongst other things, that his property rights in the cells had been compromised. The Supreme Court of California decided that it was inappropriate to recognise property in the body because it would hinder medical research and there was no precedent. However, as was pointed out by Broussard J, dissenting, the majority's argument rests not on a no property rule but 'on the proposition that a patient retains no ownership interest in a body part once the body part has been removed'. The plaintiff did succeed in negligence on the grounds that his consent had not been fully informed.

Think point

Is it justified that drug companies and researchers can make significant profits from a patient's body and yet the patient has no right to maintain an interest in those body parts?

7.5.2 The next of kin may have no right to have body parts returned for burial

Dobson v North Tyneside HA (1996) CA

The deceased's brain was removed and preserved in paraffin during a coroner's post mortem. Once it was no longer required the hospital disposed

of the brain. The deceased's family required the brain for evidence in a medical negligence action against the hospital. They brought a claim in conversion against the hospital.

Held: the hospital was not liable. The brain had not undergone any process that might have generated property rights (*Doodeward v Spence* approved). There was no right of possession vested in the relatives. Only the legal executor or administrator had any rights of possession and then only with a view to burial.

8 Abortion and Reproductive Law

8.1 The legal status of the fetus

8.1.1 The fetus is not a legal person

St Georges Healtzhcare NHS Trust v S; R v Collins and Others ex p S (1998) CA

For the facts and decision, see 5.1.2.

The Court of Appeal stated:

> Although human, and protected by the law…an unborn child is not a separate person from its mother. Its need for medical assistance does not prevail over her rights.

Attorney General's Reference (No 3 of 1994) (1998) HL

The accused stabbed a pregnant woman causing the child to be born alive but prematurely. The child subsequently died because of its prematurity rather than through any direct injury from the stabbing.

Held: although a fetus was not a living person, the possibility of a dangerous act directed at a pregnant woman causing harm to a child to whom she subsequently gave birth made it permissible on public policy grounds to regard that child as within the scope of the defendant's *mens rea* when committing the unlawful act.

Lord Mustill stated:

> It is sufficient to say that it is established beyond doubt for the criminal law, as for the civil law (*Burton v Islington HA* (1993)), that the child *en ventre sa mere* does not have a distinct human personality whose extinguishment gives rise to any penalties or liabilities at common law.

See, also, *Paton v British Pregnancy Advisory Service Trustees* (1979). Sir George Baker said:

The fetus cannot, in English law, in my view, have a right of its own at least until it is born and has a separate existence from its mother.

8.1.2 The fetus is not protected by the European Convention on Human Rights

Paton v UK (1980) EComHR

The claimant had failed in the English courts to gain an injunction to prevent his wife from having an abortion under the Abortion Act 1967. He subsequently claimed that the fetus had a right to life and an abortion would breach Art 2 (right to life) of the European Convention on Human Rights.

Held: the Commission denied that allowing the abortion of a fetus during the first half of pregnancy would be a breach of Art 2.

The Commission noted that the word 'everyone' was not defined in the Convention but 'both the general usage of the term "everyone" in the Convention and the context in which this term is employed in Art 2 tend to support the view that it does not include the unborn'. In *H v Norway* (1992), the Commission held that abortions on social grounds were not contrary to Art 2. This case involved a 14 week fetus so it may not be relevant to the rights of a viable fetus. It remains open whether a viable fetus has a limited right to life under the Convention, but it is suggested that in any conflict between the health or life of the pregnant woman and the fetus' right to life, then the woman's rights will trump those of the fetus.

Note

This case only applies to a non-viable fetus since the Commission declined to consider whether the fetus at any stage of pregnancy had a limited right to life. It did argue that an absolute right would be untenable because it 'would mean that the "unborn life" of the foetus would be regarded as being of a higher value than the life of the pregnant woman'.

Think point

The fetus is not a legal person, but what is its moral status?

8.2 The legal protection of the fetus

8.2.1 The fetus is protected from abortions that are not lawful under the Abortion Act 1967

Section 58 of the Offences Against The Person Act 1861

Every woman, being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of a felony, and being convicted thereof shall be liable…to be kept in penal servitude for life.

Note

For a woman to be liable under this section, she must actually be pregnant; if a third party attempts to induce the miscarriage she does not have to be pregnant. Also, the attempt to induce a miscarriage need not be successful.

8.2.2 Intentional destruction of a child capable of being born alive is an offence

Section 1 of the Infant Life (Preservation) Act 1929

(1) …any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother, shall be guilty of…child destruction, and shall be liable on conviction…to penal servitude for life.
…no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.

(2) For the purposes of this Act, evidence that a woman had at any material time been pregnant for a period of 28 weeks or more shall be *prima facie* proof that she was at that time pregnant of a child capable of being born alive.

Note

The Act was drafted to cover the *lacuna* in the law that existed after the child had been born but was not independent of the mother (before the umbilical cord had been cut) when destruction of the child was neither homicide nor an offence under the Offences Against the Persons Act 1861. However, the Act has a much wider effect than was intended, since

it covers any fetus that is capable of being born alive. Note that omissions or reckless or negligent acts do not incur liability under the Act.

8.2.3 The meaning of 'capable of being born alive' is that the fetus can breathe independent of its mother

C v S (1988) CA

The plaintiff sought an injunction to prevent the mother of his 18–21 week fetus from aborting the child. One of the grounds for the injunction was that the child was capable of being born alive and so was protected by the Infant Life (Preservation) Act 1929.

Held: injunction not granted.

Sir John Donaldson MR stated:

> We have no evidence of the state of the fetus being carried by the first defendant, but if it has reached the normal stage of development, and so is incapable ever of breathing, it is not in our judgment 'a child capable of being born alive' within the meaning of the Act.

See, also, *Rance v MidDowns HA* (1991).

Note

The child will still be capable of being born alive even if it is incapable of breathing without assistance from a ventilator.

8.2.4 The fetus can be the victim of negligence but only if subsequently born alive

Section 1 of the Congenital Disabilities (Civil Liability) Act 1976

(1) If a child is born disabled as the result of such an occurrence before its birth as is mentioned in sub-section (2) below, and a person (other than the child's own mother) is under this section answerable to the child in respect of the occurrence, the child's disabilities are to be regarded as damage resulting from the wrongful act of that person and actionable accordingly at the suit of the child.

(2) An occurrence to which this section applies is one which—

(a) affected either parent of the child in his or her ability to have a normal, healthy child; or

(b) affected the mother during her pregnancy, or affected her or the child in the course of its birth, so that the child is born with disabilities which would not otherwise have been present.

Note

The Act only covers children born after 22 July 1976. Prior to that, the common law allowed that negligent damage to a fetus could give rise to liability to the child once it is born alive (*Burton v Islington HA* (1992)). The action is derivative via a tort committed against either the mother or the father (s 1(3)). A mother cannot be liable to her own child except for negligent driving (s 2), but a father can be liable for any tort against the mother. The Act has been extended by s 44(1) of the Human Fertilisation and Embryology Act, which inserts s 1A to cover negligent acts that damage eggs, sperm or embryos prior to implantation during infertility treatment.

Think point

What is the justification for protecting the mother, but not the father, from all liability for negligence to the fetus except negligent driving?

8.2.5 Even though there can be no liability to the child if it is stillborn, there will still be liability to the mother for the loss of the child

Bagley v North Herts HA (1986)

The negligent actions of the defendants in failing to carry out blood tests and deliver the child early by caesarean section resulted in the birth of a stillborn child. The plaintiff sued for damages.

Held: she was not entitled to damages for loss of the society of her stillborn son. However, damages were available for:

(1) the loss of satisfaction from a successful conclusion to her pregnancy;
(2) the physical loss of her child and the loss from being unable to complete her family by adding a second child to it;
(3) the physical illness brought on the plaintiff by her grave misfortune.

8.2.6 A fetus cannot be made a ward of court

Re F (In-Utero) (1988) CA

A pregnant woman with a history of psychiatric problems lived in a local authority residential home. She went missing from the home when she was in the 38th week of her pregnancy. The Local Authority sought an order to make her fetus a ward of court.

Held: the request was denied.
Staughton LJ stated:

When the wardship jurisdiction of the High Court is exercised, the rights, duties and powers of the natural parents are taken over or superseded by the orders of the court. Until a child is delivered it is not, in my judgment, possible for that to happen… The orders sought by the Local Authority…are orders which seek directly to control the life of both mother and child. As was said by the European Commission of Human Rights in *Paton v UK*…'the 'life' of the fetus is intimately connected with, and cannot be regarded in isolation from, the life of the pregnant woman'…

Note

Although the fetus cannot be made a ward of court, the House of Lords have held that the mother's behaviour while she was pregnant can be taken into account when making care orders after the child is born: *Re D (A Minor)* (1986) HL.

8.3 Abortion

8.3.1 For an abortion to be lawful it must be performed by a registered medical practitioner

Section 1 of the Abortion Act 1967

See 8.3.3.

8.3.2 Nursing staff may administer drugs to induce an abortion, providing the procedure is under the direction of a doctor

Royal College of Nursing of UK v DHSS (1981) HL

A DHSS circular authorised the practice of nurses administering prostaglandin to induce an abortion. The RCN sought a declaration that the circular was unlawful.

Held: (3:2 majority) providing the nurse was acting on the instructions of the doctor who remained responsible for the procedure, then the procedure would be within the wording of s 1(1) of the Abortion Act 1967.

8.3.3 An abortion may be lawful within the first 24 weeks of pregnancy

Section 1 of the Abortion Act 1967

(1) Subject to the provisions of this section, a person shall not be guilty of any offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two medical practitioners are of the opinion, formed in good faith—

(a) that the pregnancy has not exceeded its 24th week and that continuance of the pregnancy would involve risk greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family…

Note

Since s 1(2) of the Abortion Act 1967 allows the woman's 'actual or reasonably foreseeable environment' to be taken into account, the fetus—up to 24 weeks' gestation—may be aborted for relatively trivial reasons (social abortion).

8.3.4 After 24 weeks, an abortion may be lawful to protect the woman from serious harm or death

Section 1 of the Abortion Act 1967

(1) Subject to the provisions of this section, a person shall not be guilty of any offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two medical practitioners are of the opinion, formed in good faith—

(b) that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or

(c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated…

8.3.5 After 24 weeks an abortion may be lawful if the fetus is abnormal

Section 1 of the Abortion Act 1967

(1) Subject to the provisions of this section, a person shall not be guilty of any offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two medical practitioners are of the opinion, formed in good faith—

(d) that there is substantial risk that if the child were born it would suffer such physical or mental abnormalities as to be seriously handicapped.

8.3.6 The doctor's opinion that the woman satisfies one of the statutory grounds must be formed in good faith

R v Smith (1974) CA

The defendant performed an abortion on a pregnant woman who subsequently became ill. It became apparent that the doctor had not obtained the necessary second opinion or satisfied himself that the woman was at greater risk from the pregnancy than from the abortion. The jury found him guilty of procuring a miscarriage contrary to s 58 of the Offences Against The Person Act 1861. The defendant appealed.

Held: appeal dismissed.

8.3.7 Healthcare professionals are not obliged to perform an abortion unless it is necessary to prevent the woman from dying or suffering grave injury

Section 4 of the Abortion Act 1967

(1) Subject to sub-s (2) of this section, no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection; …provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.

(2) Nothing in sub-s (1) of this section shall affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman.

8.3.8 The conscientious objection clause does not apply to acts ancillary to the performance of an abortion

Janaway v Salford HA (1989) HL

The plaintiff was a medical secretary. She was a practising Roman Catholic, and because of her religious views she refused to type a referral letter regarding an abortion. She was dismissed from her post. She subsequently brought an action for unfair dismissal on the grounds that s 4(1) of the Abortion Act 1967 protected her refusal.

Held: typing the letter was an ancillary act and was not covered by s 4(1).

8.3.9 The father of the fetus has no rights regarding a woman's decision to seek an abortion

Paton v British Pregnancy Advisory Service Trustees (1979)

The plaintiff sought an injunction to prevent his wife from terminating her pregnancy. She had obtained the necessary certificates from two medical practitioners but the plaintiff alleged that she was acting in bad faith.

Held: the request for an injunction was turned down.

Note

In *Paton v UK,* the European Commission dismissed the claim that Mr Paton's right to respect for family life—protected by Art 8 of the European Convention on Human Rights—had been infringed. The lack of any paternal rights is also true in Scotland: *Kelly v Kelly* (1997) Inner House.

8.4 Post-coital contraception

The types of contraception that work post fertilisation but pre-implantation include the IUD (intrauterine device) and post-coital emergency high dose oral contraceptives. The Attorney General stated in his opinion that preventing implantation is not procuring a miscarriage and so is not an offence under the Offences Against The Person Act 1861 (41 Official Report (6th series) col 239,10 May 1983). Also, since post-coital contraception has been effectively sanctioned by the government making provisions for the emergency contraceptive pill to be available without prescription to women over 16, it would be difficult to argue that it is unlawful. See: The Prescription Only Medicines (Human Use) Amendment (No 3) Order 2000.

Think point

What are the potential difficulties with post-coital contraception?

8.4.1 A doctor who does not know or believe the woman is pregnant will not be committing an offence if he administers post-coital contraception to the woman

R v Price (1969) CA

A woman told the defendant that she was pregnant and wanted an abortion. The doctor told her that he did not believe her to be pregnant and fitted her with an IUD. She miscarried two days later. She was seen by a police surgeon shortly before the miscarriage who stated that she was 'manifestly' pregnant.

The accused was convicted of inducing a miscarriage under the Offences Against The Person Act 1861. The accused appealed.

Held: conviction quashed. The jury had been misdirected and there was insufficient evidence that the doctor believed the woman to be pregnant.

Sachs LJ stated:

> The essential issue for the jury was, did the appellant…know or believe that the patient was pregnant and, accordingly, introduce the instrument with intent to procure a miscarriage.

Note

In *R v Dhingra* (1991), a doctor fitted his secretary with an IUD 11 days after they had had intercourse. The judge withdrew the case from the jury after hearing evidence that implantation could not have occurred by this time.

8.5 Infertility and assisted reproduction

Regulation of assisted reproduction and *in vitro* research on human embryos is governed by the Human Fertilisation and Embryology Act 1990 (HFEA). Under s 4(1) of the HFEA, the use of third party gametes is only lawful if done under licence. Under s 5 of the HFEA, the Human Fertilisation and Embryology Authority has the power to issue licences to specified persons to store or use eggs, sperm and embryos for treatment or research in defined premises (ss 11,12). Embryos may not be kept beyond the appearance of the primitive streak at 14 days after the gametes are mixed (s 4(3)). Gametes may normally only be stored for up to 10 years (s 14(3)), while embryos may not be stored for more than five years (s 14(4)). These periods may be extended under certain conditions such as where the donated gametes are for the use of the couple who donated them and where the donor is likely to become prematurely infertile (Human Fertilisation and Embryology (Statutory Storage Period) Regulations 1991). A similar extension for embryo storage—which also covers donations to third parties—is provided for by reg 2 of the Human Fertilisation and Embryology (Statutory Storage Period for Embryos) Regulations 1996.

8.5.1 Gametes and embryos may only be stored and used with the donors consent

Schedule 3 to the Human Fertilisation and Embryology Act 1990

1 A consent under this Schedule must be given in writing…
2 (1) A consent to the use of any embryo must specify one or more of the following purposes—

(a) use in providing treatment services to the person giving consent, or that person and another specified person together;
(b) use in providing treatment services to persons not including the person giving consent; or
(c) use for the purposes of any project or research;

may specify conditions subject to which the embryo may be so used.

(2) A consent to the storage of any gametes or any embryo must—

(a) specify the maximum period of storage (if less than the statutory storage period); and
(b) state what is to be done with the gametes or embryo if the person who gave the consent dies or is unable because of incapacity to vary the terms of the consent or to revoke it;

and may specify conditions subject to which the gametes or embryo may remain in storage.

R v Human Fertilisation and Embryology Authority ex p Blood (1997) CA

Shortly before his death and while he was in a coma, sperm was extracted from Mr Blood and placed in storage. After his death, Mrs Blood wanted to be impregnated with the sperm but the HFEA refused to grant a licence because there was no written consent from Mr Blood to allow his sperm to be stored and used. Mrs Blood sought a judicial review of the Authority's decision.

Held: the storage of the sperm had been unlawful and the Authority was correct to refuse the licence to Mrs Blood.

Note

The Court of Appeal held that although Mrs Blood was not entitled to be treated in this country, she was lawfully entitled to take the sperm and receive treatment in Belgium under Art 59 of the EC Treaty.

8.5.2 The donor of the egg or sperm cells will not be regarded as the legal parent of the child

Human Fertilisation and Embryology Act 1990

Section 27 Meaning of 'mother'

(1) The woman who is carrying or has carried a child as a result of the placing in her of an embryo or of sperm and eggs, and no other woman, is to be treated as the mother of the child.

Section 28 Meaning of 'father'

(1) This section applies in the case of a child who is being or has been carried by a woman as the result of the placing in her of an embryo or of sperm and eggs or her artificial insemination.
(2) If—

(a) at the time of the placing in her of the embryo or the sperm and eggs or of her insemination, the woman was a party to a marriage; and
(b) the creation of the embryo carried by her was not brought about with the sperm of the other party to the marriage;

then, subject to sub-s (5) below, the other party to the marriage shall be treated as the father of the child unless it is shown that he did not consent to the placing in her of the embryo or the sperm and eggs or to her insemination.

(3) If no man is treated, by virtue of sub-s (2) above, as the father of the child but –

(a) the embryo or the sperm and eggs were placed in the woman. Or she was artificially inseminated, in the course of treatment services provided for her and a man together by a person to whom a licence applies; and
(b) the creation of the embryo carried by her was not brought about with the sperm of that man, then, subject to sub-s (5) below, that man shall be treated as the father of the child.

(4) Where a person treated as the father of the child by virtue of sub-ss (2) or (3) above, no other person is tzo be treated as the father of the child.
(5) Sub-sections (2) and (3) above do not apply—

(a) in relation to England and Wales and Northern Ireland, to any child who, by virtue of the rules of common law, is treated as the legitimate child of the parties to marriage;
(b) in relation to Scotland, to any child who, by virtue of any enactment or other rule of law, is treated as the child of the parties to a marriage; or
(c) to any child to the extent that the child is treated by virtue of adoption as not being the child of any person other than the adopter or adopters.

(6) Where—

(a) the sperm of a man, who had given such consent as is required by para 5 of Sched 3 to this Act, was used for a purpose for which such consent was required; or
(b) the sperm of a man, or any embryo, the creation of which was brought about with his sperm, was used after his death;

he is not to be treated as the father of the child.

8.6 Surrogacy

Surrogacy arrangements are regulated by the Surrogacy Arrangements Act 1985 as amended by the Human Fertilisation and Embryology Act 1990. The Act was passed following a wardship case that concerned a child born following a surrogacy arrangement *(Re C (A Minor)* (1985)). Section 1(2) of the Act defines a surrogate mother as:

…a woman who carries a child in pursuance of an arrangement—
(a) made before she began to carry the child, and
(b) made with a view to any child carried in pursuance of it being handed over to, and the parental rights being exercised (so far as practicable) by, another person or persons.

Note

Arrangements made after a woman becomes pregnant are not covered by the Act. The Act makes it a criminal offence to negotiate or compile information about surrogacy arrangements (s 2(1)). However, this does not apply to either the commissioning couple or the surrogate mother (s 2(2)). Advertisements regarding surrogacy arrangements are also outlawed (s 3) and there is no exception for the surrogate mother or commissioning couple.

8.6.1 Surrogacy arrangements are not legally enforceable

Surrogacy Arrangements Act 1985 (as amended)

(1A) No surrogacy arrangement is enforceable by or against any of the persons making it…

A v C (1985) CA

The plaintiff's partner was unable to bear the child that he wanted to father so they arranged for the friend of a prostitute to be a surrogate for a fee of £3,000. C was artificially impregnated with the plaintiff's sperm but she subsequently changed her mind and decided to keep the child. The plaintiff

applied to the court. At first instance, custody was left with C, but the plaintiff was given an order for access. C appealed.

Held: appeal granted. The order made would be withdrawn and the plaintiff would have no access rights to the child.

Note

Although reported in 1985, this case was heard in 1978 and was prior to the Surrogacy Arrangements Act 1985. Where custody is disputed, the courts will consider what is in the child's interests rather than those interests of the adult parties. In *Re P (Minors)* (1987), a surrogate mother was allowed to retain custody of twins who were made wards of court. Sir john Arnold P stated: 'In this, as in any other wardship dispute, the welfare of the children, or child, concerned is the first and paramount consideration which the court must, by statute, take into account…' In that case, the fact that the children had bonded with the surrogate mother—who provided a satisfactory level of care—was determinative.

8.6.2 Where the commissioning couple provide one or both of the gametes they may apply for a parental order

Section 30 of the Human Fertilisation and Embryology Act 1990

(1) The court may make an order providing for a child to be treated in law as the child of the parties to a marriage…if—

   (a) the child has been carried by a woman other than the wife as the result of placing in her of an embryo or sperm and eggs or her artificial insemination;
   (b) the gametes of the husband or the wife, or both, were used to bring about the creation of the embryo; and
   (c) the conditions in sub-ss (2)–(7) below are satisfied.

(2) The husband and wife must apply for the order within six months of the birth of the child…
(3) At the time of the application and of the making of the order—

   (a) the child's home must be with the husband and the wife; and
   (b) the husband or the wife, or both of them, must be domiciled in…the United Kingdom or in the Channel Islands or the Isle of Man.

(4) At the time of making the order, both the husband and the wife must have attained the age of 18.

(5) The court must be satisfied that both the father of the child…where he is not the husband, and the woman who carried the child have freely, and with full understanding of what is involved, agreed unconditionally to the making of the order.
(6) Sub-section (5) above does not require the agreement of a person who cannot be found, or is incapable of giving agreement, and the agreement of the woman who carried the child is ineffective for the purposes of that sub-section, if given by her less than six weeks after the child's birth.
(7) The court must be satisfied that no money or other benefit (other than for expenses reasonably incurred) has been given or received by the husband or the wife for or in consideration of—

(a) the making of the order;
(b) any agreement required by sub-s (5) above;
(c) the handing over of the child to the husband and the wife; or
(d) the making of any arrangements with a view to the making of the order; unless authorised by the court.

Re Q (Parental Order) (1996)

The commissioning couple, Mr and Mrs B, paid a surrogate (Miss A) £8,280 expenses for carrying an implanted embryo for them. After the child was born, the surrogate had some misgivings and visited a solicitor with regard to securing the child's placement with her. On reflection she subsequently agreed to the parental order.

Held: parental order granted. It was reasonable to pay Miss A £5,000 as compensation for loss of earnings and the £3,280 was a reasonable sum to cover the expenses of pregnancy and child care provision for her other children while she was attending hospital, etc.

Note

The authorisation for the expenses was given retrospectively following *Re Adoption Application (Payment for Adoption)* (1987). The court also held that, despite being the genetic father, Mr B was not the legal father of the child under s 28 of the Human Fertilisation and Embryology Act 1990.

8.7 Wrongful life and wrongful birth

8.7.1 Being born is not a legal harm for which a child may claim damages

McKay v Essex AHA (1982) CA

The plaintiff was born with severe congenital disabilities after her mother had contracted rubella while pregnant. Her mother had been wrongly informed that she had not been infected and there was no need to consider an abortion. It was not disputed that the defendants were liable for causing her disabilities but she also claimed for the fact that she had been born at all 'into a life in which her injuries are highly debilitating'.

Held: the claim for 'wrongful life' was denied. The proposition that there could be a duty to prevent a child from being born was contrary to the sanctity of life. Furthermore, the claim involved an impossible comparison between a disabled existence and non-existence.

8.7.2 An unwanted pregnancy is a legally recognised harm, but the birth of a healthy child is not

McFarlane v Tayside HB (2000) HL

The claimants were husband (P1) and wife (P2). Following a vasectomy, P1 was advised that his sperm count was negative and he no longer needed to take contraceptive precautions. The claimants followed this advice and P2 became pregnant. At first instance, Lord Gill dismissed the claims. He decided that pregnancy and childbirth did not constitute a personal injury and 'the privilege of being a parent is immeasurable in money terms and that the benefits of parenthood transcend any patrimonial loss'. On appeal, the Inner House reversed the decision and held that the benefits of parenthood could not outweigh the damage caused by the unwanted pregnancy. The defendants appealed.

Held: the appeal against damages for the unwanted pregnancy, and the costs flowing from that, was dismissed. The appeal against the costs of raising the child would be allowed.

Lord Steyn argued that the 'traveller on the Underground' would instinctively reply 'that the law of tort had no business to provide legal remedies consequent upon the birth of a healthy child, which all of us regard as a valuable and good thing'.

Note

All of the judges applied the 'limited damages rule' (see Stewart (1995)) and denied the claim for the maintenance costs of a healthy child. There were a number of reasons which included: child maintenance is pure economic loss; the unjust enrichment that would result from compensating the parents for child maintenance costs; the moral intuition ascribed to the 'traveller on the Underground'; the potential scale of the damages; the incoherence of allowing a claim for wrongful birth but not wrongful life; judicial disquiet with the award of maintenance damages.

8.7.3 The costs of raising an unwanted disabled child may still be recoverable

Rand v East Dorset HA (2000)

The defendants negligently failed to inform the claimants of the result of a routine scan which suggested that Mrs Rand was pregnant with a Down's syndrome fetus. They were deprived of the opportunity to seek an abortion. It was accepted that Mrs Rand, had she known of the scan results, would have aborted her pregnancy. The child was born with Down's syndrome. The claimants claimed for full maintenance costs, educational costs to the age of 18, and the cost of her care for life.

Held: following *McFarlane v Tayside,* the full cost of maintenance was not recoverable because it would entail a comparison of the existence and non-existence of the child. The losses relating to the disability, although still economic loss, were recoverable.

Note

Although their Lordships in *McFarlane v Tayside* specifically declined to consider the position of the disabled child, the argument they used for denying recovery for the maintenance of a healthy child should logically also exclude recovery for the disabled child. Their lordships rejected the 'benefits rule' that the benefits of having the child should be deducted from the damages allowed for maintenance costs. This was based on the argument that the benefits of having a child could not be calculated and thus, the award of damages should be all or none. However, since Rand is only a first instance decision, the question of whether the parental costs resulting from a child's disability can be recovered is not settled with certainty. See, also, *Carver v Hammersmith & Queen Charlotte's Special HA* (2000), in which the High Court held that the cost of raising a disabled child went to quantum of damages not liability.

Think point

Can this case be rationalised with the judgment in *McFarlane v Tayside?*

8.7.4 Where the claimant is aware that a sterilisation has failed there will be no liability for wrongful conception

Sabri-Tabrizi v Lothian HB (1998) SC

Following a failed sterilisation, the pursuer became pregnant. The pregnancy was terminated. She subsequently became pregnant (she claimed they were using condoms) for a second time but miscarried the pregnancy. As a preliminary point, the court was asked to decide whether the second pregnancy was caused by the failed sterilisation operation.

Held: the use of a condom was irrelevant since there was a risk of pregnancy when using them. Acceptance of this risk was a *novus actus interveniens* that broke the chain of causation and relieved the defenders of liability.

8.7.5 The limitation period for claims runs from the time of the injury and not from the child's birth

Walkin v South Manchester HA (1995) CA

The plaintiff underwent a sterilisation operation. She subsequently became pregnant but did not start legal proceedings until four years later. At first instance, the court held that any claim was time barred.

Held: appeal dismissed. The personal injury was the impairment of the plaintiff's physical condition by the unwanted pregnancy. This arose at the time of conception and not at the birth of the child.

9 Mental Health Law

It is worth noting that, outside specific statutory provisions, the normal principles of medical law will apply. Thus, simply because a person has a mental illness does not mean that they are automatically subject to different legal principles. Currently, statutory regulation of the care of the mentally ill is governed by the Mental Health Act (MHA) 1983. However, the Act has been reviewed by the Richardson Committee and a Government White Paper proposing a number of changes to the Act. For an analysis of the proposals, see Laing (2000).

9.1 The definition of mental disorder

9.1.1 The statutory definitions

Section 1 of the MHA 1983

(2) In this Act—

'mental disorder' means mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind …

'mental impairment' means a state of arrested or incomplete development of mind (not amounting to severe mental impairment) which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned…

'psychopathic disorder' means a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned…

Note

Alcohol and drug dependency, promiscuity, sexual deviancy and immoral conduct are insufficient by themselves to count as a mental disorder. See *R v Mental Health Review Tribunal ex p Clatworthy* (1985), in which the court rejected the tribunal's argument that sexual deviancy could have the features of mental disorder. The court held

that sexual deviancy should be discounted as a mental disorder by virtue of s 1(3).

9.1.2 The phrase 'mental illness' is not a term of art should be given its ordinary meaning

W v L (1974) CA

A young man committed a number of cruel acts including hanging a puppy, cutting a cat's throat and putting another cat in a gas oven. After threatening his wife, he was compulsorily admitted as an emergency under the MHA 1959. This order expired after 72 hours and an application was made, under s 27, to the court to prolong the detention. Since the wife objected, the detention could not be prolonged unless it could be established that the man was suffering from a mental illness.

Held: the detention could be prolonged as he was suffering from a mental illness.

Lawton LJ stated:

> The words [mental illness] are ordinary words of the English language. They have no particular medical significance. They have no particular legal significance…ordinary words of the English language should be construed in the way that ordinary sensible people would construe them…what would the ordinary sensible person have said about the patient's condition in this case if he had been informed of his behaviour to the dogs, the cat and his wife? In my judgment, such a person would have said: 'Well, the fellow is obviously mentally ill.'

Think point

What are the implications of this test for mental illness?

9.1.3 In determining that an individual has a mental impairment, the words 'seriously irresponsible conduct' should be interpreted restrictively

Re F (A Child) (Care Order: Sexual Abuse) sub nom In Re F (Mental Health Act: Guardianship) (2000) CA

F was a 17 year old girl with the mental age of a 5–8 year old, who had been placed on the Child Protection Register because of neglect and sexual abuse. Her younger siblings were also on the Register and had been made the subjects of care orders. F was too old to be subject to a care order but lived voluntarily in a residential home. Her parents expressed the wish that she should return home and her father withdrew his consent to her

voluntary residence. The Local Authority sought a guardianship order under s 7 of the MHA 1983. Her father objected and the Local Authority sought an order under s 29 of the MHA to be allowed to carry out the functions of the nearest relative because of his 'unreasonable objection'. To be made the subject of the guardianship order, F had to fall within the statutory definition of mental impairment and, it was disputed that, while she exhibited signs of 'a state of arrested or incomplete development of mind', this was not associated with 'seriously irresponsible conduct'. At first instance, the judge held that F's expressed wish to return home to an environment in which she was at risk of neglect and sexual exploitation was 'seriously irresponsible conduct'. The order was granted and F's father appealed.

Held: appeal allowed. The White Paper, *Review of the MHA 1959* (Cmnd 7320), supported a restrictive interpretation of 'seriously irresponsible conduct'. Given that the consequences of returning home (that is, the neglect and sexual abuse) were in dispute and would not be settled until a subsequent hearing, F's desire to return home could not be seen as seriously irresponsible.

Note

The Court of Appeal noted that the Law Commission in its report on Mental Incapacity stated that 'the vast majority of those with a learning disability…will be excluded from guardianship'. The Court of Appeal's view was that while there was doubt as to the actual risk faced by F, it could not be unreasonable to return to the source of the alleged risk.

9.2 Compulsory admission to hospital

9.2.1 Admission for assessment

Section 2 of the Mental Health Act 1983

(2) An application for admission for assessment may be made in respect of a patient on the grounds that—

(a) he is suffering from a mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
(b) he ought to be so detained in the interests of his own health or safety with a view to the protection of other persons.

Note

The period allowed for detention under this section is 28 days (s 2(4)). The application can be made either by the patient's 'nearest relative' (as defined by s 26) or by an approved social worker, on the basis of a written recommendation by two registered medical practitioners (s 2(3)). At least one of the medical practitioners must be approved under s 12(2).

9.2.2 Admission for treatment

Section 3 of the Mental Health Act 1983

(2) An application for admission for treatment may be made in respect of a patient on the grounds that—

(a) he is suffering from a mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and
(b) in the case of a psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition; and
(c) it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section.

Note

Again, the application must be made on the basis of recommendations from two doctors. If the application is made by an approved social worker, the nearest relative should be consulted. The admission period lasts for six months initially which may be renewed for a further six months and then yearly. For renewals under s 20(4), the responsible medical office must believe that further treatment is likely to alleviate or prevent deterioration in the patient's condition or be for the safety of others. Where the patient suffers from mental illness or severe mental impairment the renewal is justified if it is likely that the patient will be open to exploitation or will be unable to care for himself.

9.2.3 Section 3 of the MHA 1983 cannot be used to allow compulsory treatment in the community

R v Hallstrom ex p W; R v Gardner ex p L (1986)

L had been admitted under s 3 of the MHA 1983 for treatment. He was subsequently granted a leave of absence under s 17. The s 3 admission was due to

expire and Dr Gardner examined L under s 20(4) in order to renew the detention. L had returned on one occasion to allow a second opinion to be obtained. One of the issues was whether the return to hospital terminated the initial leave of absence such that L was subsequently on a second leave of absence. If a leave of absence lasts longer than six months, then the patient is no longer under the control of the Act (s 17(5)). As the second period of leave approached the six month deadline, L was asked to return to the hospital. L alleged that, either his leave of absence had expired or the recall was an abuse of law with the single night return to the hospital being used as a device for keeping the leave of absence going.

Held: although s 20 could be used to renew a s 3 admission, the renewal must be because the patient needs to be in hospital and not simply to allow repeated leaves of absence and compulsory treatment in the community.

McCullough J stated:

> It stretches the concept of 'admission for treatment' too far to say that it covers admission for only so long as it is necessary to enable a leave of absence to be granted after which the necessary treatment will begin…the concept of 'admission for treatment' has no applicability to those whom it is intended to admit and detain for a purely nominal period, during which no necessary treatment will be given.

Note

Under the MHA, a leave of absence could only last six months but this has been extended by Mental Health (Patients in the Community) Act 1995 so that the leave can last up until the patient's section is due for renewal.

9.2.4 In the case of psychopathic disorder or mental illness, the 'treatability' requirement of s 3(2)(b) would be satisfied simply if the treatment would prevent deterioration

R v Cannons Park Mental Health Review Tribunal ex p A (1994) CA

A was suffering from a psychopathic disorder which might be treated by group therapy. The Mental Health Review Tribunal (MHRT) found that, as she was unco-operative, the group therapy was unlikely to be an effective treatment. She was, therefore, deemed untreatable but the MHRT detained her in the interests of her own health and safety and for the protection of others. A applied for judicial review and the Divisional Court held that, because the treatment would neither alleviate nor improve A's condition, the matter should be remitted to the tribunal with a direction that they should discharge A. The MHRT appealed.

Held: appeal allowed. The Divisional Court had been in error and had taken too narrow a view of the treatability test which would be satisfied

provided that it prevents a deterioration. A patient should not be considered untreatable because of their refusal to co-operate.

Roch LJ defined the following principles:

> First, if a tribunal were to be satisfied that the patient's detention in hospital was simply an attempt to coerce the patient into participating in group therapy, then the tribunal would be under a duty to direct discharge. Secondly, treatment in hospital will satisfy the treatability test although it is unlikely to alleviate the patient's condition, provided that it is likely to prevent a deterioration. Thirdly, treatment in hospital will satisfy the treatability test although it will not immediately alleviate or prevent deterioration in the patient's condition provided that alleviation or stabilisation is likely in due course. Fourthly, the treatability test can still be met although initially there may be some deterioration in the patient's condition due, for example, to the patient's initial anger at being detained. Fifthly, it must be remembered that medical treatment in hospital covers nursing and also includes care, habilitation and rehabilitation under medical supervision. Sixthly, the treatability test is satisfied if nursing care, etc, are likely to lead to an alleviation of the patient's condition in that the patient is likely to gain an insight into his problem or cease to be unco-operative in his attitude towards treatment which would potentially have a lasting benefit.

Note

The treatability requirement is to be removed as part of the Government's plans for reform of the MHA.

Think point

Is the Court of Appeal's decision justified where the treatment inherently requires the patient's co-operation to be successful?

9.2.5 Admission for emergency assessment

Section 4 of the MHA 1983

(1) In any case of urgent necessity, an application for admission for assessment may be made in respect of a patient in accordance with the following provisions of this section, and any application so made is in this Act referred to as 'an emergency application'.

(2) An emergency application may be made either by an approved social worker or by the nearest relative of the patient; and every such application shall include a statement that it is of urgent necessity for the patient to be admitted and detained under s 2 above, and that compliance with the provisions of this part of this Act relating to applications under that section would involve undesirable delay.

(3) An emergency application shall be sufficient in the first instance if founded on one of the medical recommendations required by s 2 above, given, if practicable, by a practitioner who has previous acquaintance with the patient and otherwise complying with the requirements of s 12 below so far as applicable to a single recommendation, and verifying the statement referred to in sub-s (2) above.

Note

There is a 72 hour time limit on admissions made under this section, unless a second medical recommendation (as required under s 2) is made (s4(4)).

9.2.6 Patients already admitted informally may be compulsorily detained

Section 5 of the MHA 1983

(1) An application for the admission of a patient to a hospital may be made under this part of this Act notwithstanding that the patient is already an in-patient in that hospital…
(2) If, in the case of a patient who is an in-patient in a hospital, it appears to the registered medical practitioner in charge of the treatment of the patient that an application ought to be made under this part of this Act for the admission of the patient to hospital, he may furnish to the managers a report in writing to that effect; and in any such case the patient may be detained in the hospital for a period of 72 hours from the time when the report is so furnished.

9.3 Non-consensual treatment

9.3.1 Patients detained under the MHA 1983 may, without their consent, be given treatment for their mental disorder

Section 63 of the MHA 1983

The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, not being treatment falling within ss 57 or 58 above, if the treatment is given by or under the direction of the responsible medical officer.

Note

The common law applies to treatment for things other than the patient's mental disorder and thus must be justified either by the patients consent or—where the patient is incapable of consenting—by the doctrine of necessity.

9.3.2 Treatment for the patient's mental disorder includes care ancillary to the core treatment

B v Croydon HA (1994) CA

B was compulsorily detained under s 3 of the MHA 1983. She suffered from a psychopathic disorder and made various attempts to harm herself. When these were frustrated, she refused to eat. The Health Authority decided to force feed her and B applied to the court for an injunction. The application was rejected at first instance. B appealed.

Held: appeal denied. Despite the 'treatability' requirement of s 3, not every act of treatment 'must in itself be likely to alleviate or prevent a deterioration of that disorder'. The definition of 'treatment given in s 145(1) is wide and includes 'nursing, and also includes care, habilitation and rehabilitation under medical supervision'. This definition includes a range of acts ancillary to the core treatment for the mental disorder.

Hoffmann LJ stated:

> It would seem to me strange if a hospital could, without the patient's consent, give him treatment directed to alleviating a psychopathic disorder showing itself in suicidal tendencies, but not without such consent be able to treat the consequences of a suicide attempt. In my judgment the term 'medical treatment …for the mental disorder' in s 63 includes such ancillary acts.

Note

In *SW Hertfordshire HA v KB* (1994), Ewbank J considered the naso-gastric tube feeding of a patient with anorexia nervosa. He stated 'relieving symptoms is just as much a part of treatment as relieving the underlying cause'. This was approved by Hoffmann LJ in *B v Croydon HA.* The concept of ancillary treatment was widened in *Thameside and Glossop Acute Services Trust v CH* (1996), to include a caesarean section. Wall J argued that, ensuring the delivery of a live baby by a caesarean section was justified since: it would prevent a deterioration of the patient's mental state; a dead baby might make her schizophrenia less responsive to treatment; and her anti-psychotic medication was interrupted by pregnancy and could not be resumed until delivery. See, also, *R v Ashworth Hospital Authority ex p Brady* (2000).

Think point

Do you agree with Hoffmann LJ's reasoning? Was Wall J justified in extending the concept to include a non-consensual caesarean section? In *B v Croydon*, Hoffmann LJ stated that *Re C (Adult: Refusal of Treatment)* was distinguishable (see 2.1.2). Do you agree with him?

9.3.3 Certain types of treatment for the patient's mental disorder require the consent of the patient and a second medical opinion

Section 57 of the MHA 1983

(1) This section applies to the following forms of medical treatment for mental disorder—

(a) any surgical operation for destroying brain tissue or for destroying the functioning of brain tissue; and
(b) such other forms of treatment as may be specified for the purposes of this section by regulations made by the Secretary of State.

(2) Subject to s 62 below, a patient shall not be given any form of treatment to which this section applies unless he has consented to it and—

(a) a registered medical practitioner appointed for the purposes of this part of this Act by the Secretary of State (not being the responsible medical officer) and two other persons appointed for the purposes of this paragraph by the Secretary of State (not being registered medical practitioners) have certified in writing that the patient is capable of understanding the nature, purpose and likely effects of the treatment in question and has consented to it; and
(b) the registered medical practitioner referred to in para (a) above has certified in writing that, having regard to the likelihood of the treatment alleviating or preventing a deterioration of the patient's condition, the treatment should be given.

(3) Before giving a certificate under sub-s (2)(b) above, the registered medical practitioner concerned shall consult two other persons who have been professionally concerned with the patient's medical treatment, and of those persons, one shall be a nurse and the other shall be neither a nurse nor a registered medical practitioner.
(4) Before making any regulations for the purpose of this section, the Secretary of State shall consult such bodies as appear to him to be concerned.

Note

(1) Patients can withdraw their consent for treatment at any time.
(2) Currently the only treatment specified by the Secretary of State is surgical implantation of hormones to reduce the male sex drive (reg 16 of the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983).

R v Mental Health Act Commission ex p X (1988)

A compulsorily detained paedophile had been treated with standard anti-androgen therapy which had failed to reduce his sex drive. His doctors decided to switch to 'goserelin' a synthetic, relatively new and experimental drug which acts to reduce testosterone levels. The drug was inserted under the skin by injection. The Commission withdrew its approval for certification of the treatment under s 57 and the patient applied for a judicial review. The issues before the court included whether the treatment qualified for s 57 certification.

Held: the Commission's decision was quashed as irrational and a s 57 certificate is not required.

(1) The drug was a synthetic 'hormone analogue' and was therefore not a 'hormone' under reg 16 of the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983.
(2) The drug was introduced by 'injection' and not by 'surgical implantation' as required by reg 16.

Note

Although it was dropped during the hearing, the applicant also raised the question of whether treatment for sexual deviancy is covered by s 57. Stuart-Smith LJ argued that treatment for sexual deviancy is not treatment for a mental disorder and is not covered by s 57, 'however, it seems likely that the sexual problem will be inextricably linked with the mental disorder, so that treatment for the one is treatment for the other, as in this case'. The 'Code of Practice' recommends that 'if there is any doubt as to whether it is a mental disorder which is being treated, independent legal and medical advice must be sought' (para 16.8).

9.3.4 Certain types of treatment for the patient's mental disorder require either the consent of the patient or a second medical opinion

Section 58 of the MHA 1983

(1) This section applies to the following forms of medical treatment for mental disorder—

(a) such forms of treatment as may be specified for the purposes of this section by regulations made by the Secretary of State;
(b) the administration of medicine to a patient by any means (not being a form of treatment specified under para (a) above or s 57 above) at any time during a period for which he is liable to be detained as a patient to whom this part of this Act applies if three months or more have elapsed since the first occasion in that period when medicine was administered to him by any means for his mental disorder.

(2) The Secretary of State may by order vary the length of the period mentioned in sub-s (1)(b) above.
(3) Subject to s 62 below, a patient shall not be given any form of treatment to which this section applies unless—

(a) he has consented to that treatment and, either the responsible medical officer or a registered medical practitioner appointed for the purposes of this part of this Act by the Secretary of State, has certified in writing that the patient is capable of understanding its nature, purpose and likely effects and has consented to it; or
(b) a registered medical practitioner appointed as aforesaid (not being the responsible medical officer) has certified in writing that the patient is not capable of understanding the nature, purpose and likely effects of that treatment or has not consented to it but that, having regard to the likelihood of its alleviating or preventing a deterioration of his condition, the treatment should be given.

(4) Before giving a certificate under sub-s (3)(b) above, the registered medical practitioner concerned shall consult two other persons who have been professionally concerned with the patient's medical treatment, and of those persons one shall be a nurse and the other shall be neither a nurse nor a registered medical practitioner.
(5) Before making any regulations for the purposes of this section, the Secretary of State shall consult such bodies as appear to him to be concerned.

Note

This treatment includes Electro-convulsive Therapy (ECT) under reg 16(2) of the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, and treatment continued for more than three months.

9.3.5 The provisions of ss 57, 58 will not apply where the treatment is immediately necessary

Section 62 of the MHA 1983

(1) Sections 57 and 58 above shall not apply to any treatment—

(a) which is immediately necessary to save the patient's life; or
(b) which (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition; or
(c) which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or
(d) which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others.

Note

Section 62(3) defines irreversible as 'unfavourable, irreversible, physical or psychological consequences'. Thus, favourable consequences, even if permanent, are not 'irreversible' for the purposes of the Act. 'Hazardous' means 'significant physical hazard'.

9.3.6 Voluntary patients, admitted informally under s 131 of the MHA, who lack the capacity to consent, may be detained and treated non-consensually under the doctrine of necessity

R v Bournewood Community and Mental Health NHS Trust ex p L (1998) HL

L was a 48 year old, severely mentally retarded, autistic man. Following more than 30 years residential care, he was discharged—on a trial basis—to paid carers, Mr and Mrs E who treated him as one of the family. He subsequently became severely agitated while at a day centre and he was taken to hospital where a psychiatrist decided that he would benefit from in-patient care. Since L made no attempt to leave or resist the consultant, Dr M, decided it was not necessary to admit him formally under the MHA 1983. Although correspondence with Mr and Mrs E explained that the plan for L was to return him to their care as soon as possible and that visits would be arranged, no programme of visits was achieved. Relations between Mr and Mrs E and the hospital broke down and they applied to the court for judicial review of the decision to detain L, a writ of habeas corpus and damages for false imprisonment and assault. The Court of Appeal allowed Mr and Mrs E's claims and awarded nominal damages of £1. The Trust appealed.

Held: appeal allowed. A hospital was entitled to admit and care for an incompetent patient informally under s 131 even though he was incapable of consenting. Although the statute was silent on the issue, this could be justified

on the basis of the common law doctrine of necessity. The doctrine of necessity also justified L's detention.

Note

This case allows non-consensual hospitalisation on the basis of assent or non-dissent without providing any of the protections afforded patients compulsorily detained under the MHA.

9.4 Protecting the mentally ill

Apart from anything else, a degree of protection is provided by the publication of the MHA Code of Practice under s 118 of the MHA. This Code gives guidance to professionals in how the MHA should be applied. In the foreword to the Code, the Secretary of State writes: 'This revised Code puts a new emphasis on the patient as an individual… Patients and their carers are entitled to expect professionals to use it' (see DoH (1999)). Amongst other things, the Code requires (para 1.1) that people affected by the Act should:

- receive recognition of their basic human rights under the European Convention on Human Rights;
- be given respect for their qualities, abilities and diverse backgrounds as individuals…;
- have their needs fully taken into account [within the limits of available resources];
- be given any necessary treatment or care in the least controlled and segregated facilities compatible with ensuring their own health or safety or the safety of others;
- be treated and cared for in such a way as to promote the greatest practicable degree of their self-determination and personal responsibility, consistent with their own needs and wishes; [and]
- be discharged from detention or other powers provided by the Act as soon as it is clear that their application is no longer justified.

9.4.1 It may be a criminal offence for a man to have sexual intercourse with a woman with severe mental impairment

Section 7 of the Sexual Offences Act 1956

(1) It is an offence, subject to the exception mentioned in this section, for a man to have unlawful sexual intercourse with a woman who is a defective.

(2) A man is not guilty of an offence under this section because he has unlawful sexual intercourse, if he does not know and has no reason to suspect her to be a defective.

9.4.2 It may be a criminal offence for a male member of staff, or a guardian, to have sexual intercourse with a female patient

Section 128 of the MHA 1959

(1) …it shall be an offence, subject to the exception mentioned in this section—

(a) for a man who is an officer on the staff of or is otherwise employed in, or is one of the managers of, a hospital or mental nursing home to have unlawful sexual intercourse with a woman who is for the time being receiving treatment for mental disorder in that hospital or home, or to have such intercourse on the premises of which the hospital or home forms part with a woman who is for the time being receiving such treatment there as an out-patient;

(b) for a man to have unlawful sexual intercourse with a woman who is a mentally disordered patient and who is subject to his guardianship under the Mental Health Act 1983 or is otherwise in his custody or care under the Mental Health Act 1983 or in pursuance of arrangements under Pt III of the National Assistance Act 1948, or the National Health Service Act 1977 or as a resident in a residential care home…

(2) It shall not be an offence under this section…if he does not know and has no reason to suspect her to be a mentally disordered patient.

Note

This section was not repealed by the MHA 1983.

9.4.3 Guardianship

Section 7 of the MHA 1983

(1) A patient who has attained the age of 16 years may be received into guardianship, for the period allowed by the following provisions of this Act, in pursuance of an application (in this Act referred to as 'a guardianship application') made in accordance with this section.

(2) A guardianship application may be made in respect of a patient on the grounds that—

(a) he is suffering from mental disorder, being mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which warrants his reception into guardianship under this section; and

(b) it is necessary in the interests of the welfare of the patient or for the protection of, other persons that the patient should be so received.

(3) A guardianship application shall be founded on the written recommendations in the prescribed form of two registered medical practitioners including in each case a statement that in the opinion of the practitioner the conditions set out in sub-s (2) above are complied with…

(5) The person named as guardian in a guardianship application may be either a local social services authority or any other person (including the applicant himself); but a guardianship application in which a person other than a local social services authority is named as guardian shall be of no effect unless it is accepted on behalf of that person by the local social services authority for the area in which he resides, and shall be accompanied by a statement in writing by that person that he is willing to act as guardian.

Note

(1) Section 8 of the MHA 1983 gives the guardian the power to require the subject to reside in a specified place (s 8(1)(a)) and to attend for medical treatment (s 8(1)(b)). The guardian also has the power to require that access to the subject is allowed for 'any registered medical practitioner, approved social worker or other person so specified' (s 81(1)(c)).

(2) In addition to the statutory provisions for guardianship, two non-statutory schemes exist to provide some protection within the community. One initiative is the 'Care Programme Approach' (CPA) implemented in 1991 to ensure co-operation between health services and social services so that the patient may be assessed to determine their needs and any risks they might pose to themselves or others. Each patient should be assigned a key worker and a programme of care should be agreed. The second initiative (NHS Executive (1994)) was to establish 'supervision registers' for those mentally ill persons at risk of committing serious violence, suicide or self-neglect. CPA is currently under review and the suggestions include: creating a two-tiered system of 'standard' CPA and 'enhanced' CPA for those at particular risk; abolishing the Supervision Registers; and take a greater account of the needs of the individual's family (DoH (2000)).

9.4.4 Patients discharged following a period of compulsory detention under the MHA may be placed under a supervision order to ensure they receive after-care

Section 25 of the MHA 1983 (as amended by the Mental Health (Patients in the Community) Act 1995)

25A(1) Where a patient—

(a) is liable to be detained in a hospital in pursuance of an application for admission for treatment; and

(b) has attained the age of 16 years,

application may be made for him to be supervised after he leaves hospital, for the period allowed by the following provisions of this Act, with a view to securing that he receives the aftercare services provided for him under s 117 below.

(3) A supervision application shall be made in accordance with this section and ss 25B and 25C below.
(4) A supervision application may be made in respect of a patient only on the grounds that—

(a) he is suffering from mental disorder, being mental illness, severe mental impairment, psychopathic disorder or mental impairment;
(b) there would be a substantial risk of serious harm to the health or safety of the patient or the safety of other persons, or of the patient being seriously exploited, if he were not to receive the after care services to be provided for him under s 117 below after he leaves hospital; and
(c) his being subject to after care under supervision is likely to help to secure that he receives the after care services to be so provided.

(5) A supervision application may be made only by the responsible medical officer.
(6) A supervision application in respect of a patient shall be addressed to the Health Authority which will have the duty under s 117 below to provide after care services for the patient after he leaves hospital.
(7) Before accepting a supervision application in respect of a patient, a Health Authority shall consult the local social services authority which will also have that duty.

9.4.5 Where there is a gap in the protection offered by the MHA, the courts could make a declaratory order in the best interests of the person justified by the doctrine of necessity

Re F (Adult: Court's Jurisdiction) (2000) CA

Following a judicial decision that F could not be made the subject of a guardianship order (see 9.1.3), her father died. Her mother wanted her to return home. The Local Authority applied to the court under its inherent jurisdiction for a declaratory order that the Local Authority could determine where F should reside. At a preliminary hearing, Johnson J held that the court did have jurisdiction under Ord 15, r 16 of the Rules of the Supreme Court 1965 to make such a declaration but that it should be exercised conservatively. T's mother appealed and argued that such an order was coercive and would give the Local Authority the same power that they had failed to achieve under the guardianship application.

It was accepted for the purposes of the appeal, that F lacked the capacity to decide where she should reside. The disputed allegation about the sexual abuse of F was also accepted for the purposes of the appeal only (these assumptions would be disputed at a substantive hearing).

Held: appeal dismissed. Although the Local Authority had no power to direct F's place of residence except under a guardianship order, the doctrine of necessity might apply and the court could grant a declaratory order. The reasons were:

(a) F lacked the mental capacity to determine what was a serious justiciable issue;
(b) the MHA did not exclude the use of a declaratory order in these circumstances;
(c) there was an obvious gap in the statutory protection and the court could act to fill the gap to prevent a vulnerable person, such as F, from being placed at risk. A declaration is a flexible remedy which may be relevant in a range of circumstances.

The case was referred back to the High Court for the judge to consider the substantive issues.

Note

See, also, *R v Bournewood Community and Mental Health NHS Trust ex p L* (9.3.6).

Think point

Compare *Re F (Adult: Court's Jurisdiction)* with *Cambridgeshire CC v R* (1995), in which the court held that a declaration could only be made in relation to a right recognised at common law. Social workers sought a declaration to prevent their client, who had been sexually abused by her father, from having contact with her family. The court held that no such declaration could be made because the only right recognised by common law was the right to associate with people. There was no right of non-association.

9.4.6 Protection for patients detained under the MHA is provided by the Mental Health Act Commission

Section 120 of the MHA 1983

(1) The Secretary of State shall keep under review the exercise of the powers and the discharge of the duties conferred or imposed by this Act so far as relating to the detention of patients or to patients liable to be detained under this Act and shall make arrangements for persons authorised by him in that behalf—

(a) to visit and interview private patients detained under this Act in hospitals and mental nursing homes; and
(b) to investigate:

(i) any complaint made by a person in respect of a matter that occurred while he was detained under this Act in a hospital or mental nursing home and which he considers has not been satisfactorily dealt with by the managers of that hospital or mental nursing home; and
(ii) any other complaint as to the exercise of the powers or the discharge of the duties conferred or imposed by this Act in respect of a person who is or has been so detained.

Note

The Commission, which was established under s 11 of the National Health Service Act 1977 and is continued under s 121 of the MHA, carries out these functions as well as reviewing treatment given under ss 57, 58 (s 61 of the MHA). The Commission may also examine and comment on conditions in hospitals.

R v Mental Health Act Commission ex p Smith (1998)

The applicant's deceased brother had been compulsorily detained under the MHA. Following his death, she made complaints to the Mental Health Act Commission (MHC). The MHC accepted jurisdiction regarding complaints about the appropriateness and illegality of the detention and the dosage of drugs that had been given to the deceased. The MHC held that it had no jurisdiction to consider complaints that the deceased had been inappropriately detained and cared for in a secure unit and that his risk of harming himself had been inadequately assessed.

Held: the decision of the Commission was quashed and the MHC ordered to fully consider the complaints. Management, control and treatment were all inseparable parts of compulsory detention and thus the MHC had the appropriate jurisdiction under s 120(1) to investigate such complaints. Complaints relating to things like bed linen or food would not be within the MHC's jurisdiction.

9.4.7 The patient may challenge their compulsory detention by way of a formal review

Section 65 of the MHA 1983 (as amended)

(1) There shall be tribunals, known as a Mental Health Review Tribunals, for the purpose of dealing with applications and references by, and in respect of, patients under the provisions of this Act.

Section 72 of the MHA 1983

(1) Where application is made to a Mental Health Review Tribunal by, or in respect of, a patient who is liable to be detained under this Act, the tribunal may in any case direct that the patient be discharged, and

(a) the tribunal shall direct the discharge of a patient liable to be detained under s 2 above if they are satisfied—

(i) that he is not then suffering from mental disorder…of a nature or degree which warrants detention in a hospital for assessment…; or

(ii) that his detention…is not justified in the interests of his own health or safety or with a view to the protection of other persons;

(b) the tribunal shall direct the discharge of a patient liable to be detained otherwise than under s 2 above if they are satisfied—

(i) that he is not then suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment…of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or

(ii) that it is not necessary for the health or safety of the patient or for the protection of other persons…

(iii) in the case of an application by virtue of para (g) of s 66(1) above, that the patient, if released, would not be likely to act in a manner dangerous to other persons or to himself.

Note

Patients have a right to apply to a tribunal once during every period of detention. Every time the detention is renewed the patient may reapply (ss 66, 72 (as amended)). Under s 68, the hospital managers must make an application on behalf of the patient by the manger for any patient who has not exercised their right to appeal within the first six months and for all those who have been detained for three years or more since their last review. Patients under a supervised after care order may also apply for review once in the first six months and then annually.

In *R v Mental Health Tribunal ex p H* (2001), the Court of Appeal held that, since s 72 of the MHA could only be interpreted as placing on the patient the burden of proof that the admission criteria were not satisfied, both ss 72 and 73 of the MHA could result in a breach of Art 5 of the ECHR and hence they were incompatible with the HRA 1998.

In *R v East London & City Mental Health NHS Trust ex p Von Brandenburg*, the applicant was discharged (under s 72 of the MHA) by the mental health review tribunal, but his discharge was deferred for a week. After six days, before leaving hospital, his doctors further detained him under s 3 of the MHA. The Court of

Appeal held that it was lawful for the doctors to detain someone under s 2 or s 3 of the MHA after a tribunal had ordered his discharge even if there had been no change in circumstances since the tribunal decision.

9.4.8 When reviewing the applicant's detention, the Mental Health Review Tribunal must give reasons for its decision

Bone v Mental Health Review Tribunal (1995)

The plaintiff appealed to the court against a decision of the Tribunal to refuse to discharge the plaintiff who was detained under s 41 of the MHA. The Tribunal gave no reasons for its decision.

Held: the Mental Health Review Tribunal Rules 1983 required the Tribunal to give reasons. A judicial review would have been a more appropriate procedure as it allowed a wider range of remedies. Fresh application for discharge recommended.

Note

If the tribunal does give reasons, but the reasons are invalid, then the court will quash the decision. See *Perkins v Bath DHA* (1990).

9.4.9 The patient may challenge their compulsory detention by way of an informal review

Section 23 of the MHA 1983 (as amended)

(1) Subject to the provisions of this section and s 25 below, a patient who is for the time being liable to be detained or subject to guardianship under this part of this Act shall cease to be so liable or subject if an order in writing discharging him from detention or guardianship (in this Act referred to as 'an order for discharge') is made in accordance with this section.

(2) An order for discharge may be made in respect of a patient—

(a) where the patient is liable to be detained in a hospital in pursuance of an application for admission for assessment or for treatment by the responsible medical officer, by the managers or by the nearest relative of the patient;

(b) where the patient is subject to guardianship, by the responsible medical officer, by the responsible local social services authority or by the nearest relative of the patient.

(4) The powers conferred by this section on any authority, trust or body of persons may be exercised [subject to sub-s (5) below] by any three or more members of that authority trust or body authorised by them in that behalf or by three or more

members of a committee or sub-committee of that authority [trust] or body which has been authorised by them on that behalf.

Note

Patients may challenge their detention by an informal administrative mechanism. The power to make a discharge order under this section is given to the hospital's managers. These 'managers' are the non-executive directors and any associate members appointed for this purpose. They are not healthcare professionals.

9.4.10 Where there was no power to detain, the patient may challenge their detention by making an application for habeas corpus

Re S-C (Mental Patient: Habeas Corpus) (1996) CA

The applicant had been compulsorily detained. The approved social worker who made the application for his detention claimed that his nearest relative, his mother, had approved the application for detention under s 3 of the MHA. The mother stated that she had not approved the application for detention. At first instance, the application for habeas corpus was refused. The applicant appealed.

Held: the application for habeas corpus was approved as the appropriate procedure where the requirements for detention have not, in fact, been satisfied.

Sir Thomas Bingham MR stated:

> …the present case is one in which, in principle, an application for habeas corpus is appropriate. There is no attempt being made to overturn any administrative decision. The object is simply to show that there was never jurisdiction to detain the appellant in the first place, a fact which on agreed evidence appears to be plainly made out.

9.4.11 Where the power to detain has been exercised inappropriately then the patient may challenge his detention by judicial review

B v Barking Havering and Brentwood Community Healthcare NHS Trust (1999) CA

B had a long history of personality problems requiring frequent admissions to hospital. She was readmitted under s 3 of the MHA after she set fire to her own home. Towards the end of the six month's detention allowed under s 3, B was granted a succession of weekly periods of leave

under s 17. At the end of the six months, B's psychiatrist sought an extension of her detention under s 20 of the MHA. B was then granted leave, renewed on a weekly basis. She applied for a writ of habeas corpus and judicial review of the hospital's procedures. She was subsequently readmitted after she took amphetamines and developed a drug induced psychosis. She later caused herself serious injuries. She acknowledged that her present detention was justified under s 3, but maintained her dispute with the initial renewal of her detention. One of the issues for the court to determine was whether habeas corpus or judicial review was the appropriate application.

Held: appeal dismissed and application rejected. Although B could not be criticised for making both applications since the relationship between them needed clarification, judicial review was to be preferred since it had a wider range of remedies available. Application for habeas corpus should be discouraged unless it was clear that no other relief would be required. *Re S-C* was approved on the facts of the case (see 9.4.10).

Note

In order for judicial review, the decision must have been irrational (*Associated Provincial Picture Houses v Wednesbury Corporation* (1948)). However, under the Human Rights Act 1998, the courts should apply the principle of proportionality. This requires: (1) a legitimate aim; (2) it could not be achieved by a means less invasive of individual rights; and (3) the importance of the objective justifies the degree of infringement of the individual rights.

9.5 Rights to services and treatment

See, also, Chapter 11 for a consideration of patient's general rights to healthcare and medical treatment.

9.5.1 There is a duty on the Health Authority and Social Services to provide the patient, who has been compulsorily detained for treatment, with 'after care' services

Section 117 of the MHA 1983 (as amended)

(1) This section applies to persons who are detained under s 3 above, or admitted to a hospital in pursuance of a hospital order made under s 37 above, or transferred to a hospital in pursuance of [a hospital direction made under s 45A above or] a transfer direction made under s 47 or 48 above, and then cease to be detained and [(whether or not immediately after so ceasing)] leave hospital.

(2) It shall be the duty of the [Health Authority] and of the local social services authority to provide, in co-operation with relevant voluntary agencies, after care services for any person to whom this section applies until such time as the [Health Authority] and the local social services authority are satisfied that the person concerned is no longer in need of such services [but they shall not be so satisfied in the case of a patient who is subject to after care under supervision at any time while he remains so subject.]

(2A) It shall be the duty of the Health Authority to secure that at all times while a patient is subject to after care under supervision—

(a) a person who is a registered medical practitioner approved for the purposes of s 12 above by the Secretary of State as having special experience in the diagnosis or treatment of mental disorders is in charge of the medical treatment provided for the patient as part of the after care services provided for him under this section; and

(b) a person professionally concerned with any of the after care services so provided is supervising him with a view to securing that he receives the after care services so provided.

Think point

What is the distinction between the duty under this section and the duty under the NHS Act 1977? Is the distinction justifiable?

9.5.2 If a Health Authority is unable to provide the after care service required they should try to obtain them from another Health Authority or refer the matter to the Secretary of State

R v Ealing DHA ex p Fox (1993)

The Mental Health Review Tribunal directed that the applicant could be discharged on the condition that a consultant psychiatrist would agree to act as his responsible medical officer. The Health Authority's psychiatrists refused. The applicant applied for judicial review and sought a declaration that the Health Authority had erred in law in refusing to provide the supervision in the community; an order of certiorari to quash the Health Authority's decision; and an order of mandamus to compel the Health Authority to provide the supervision.

Held: the declaration and the order of certiorari were granted. The order of mandamus was refused since the court was not prepared to order the doctors to act against their will 'where the doctor's refusal arises from an honestly held clinical judgment that the treatment is not in the patient's best interests or is not in the best interests of the community'.

Otton J stated:

> …the mere acceptance by the Health Authority of the doctors' opinions is not of itself a sufficient discharge of their obligations… In my judgment, if the… Health Authority's doctors do not agree with the conditions imposed by the Mental Health Review Tribunal and are disinclined to make the necessary arrangements…[the] Health Authority cannot let the matter rest there…[The] Health Authority is under a continuing obligation to make further endeavours to provide arrangements within its own resources or to obtain them from other health authorities who provide such services so as to put in place practical arrangements for enabling the applicant to comply with conditions imposed… or at the very least, to make inquiries of other providers of such services. If the arrangements still cannot be made then the… Health Authority should not permit an impasse to continue but refer the matter to the Secretary of State, to enable him to consider exercising his power to refer the case back to the Mental Health Review Tribunal under s 71(1).

9.5.3 The Mental Health Review Tribunal has no power to police the provision of after care services

R v Mental Health Review Tribunal ex p Hall (2000) CA

The respondent was granted a conditional discharge which proved difficult to satisfy. The conditions were relaxed, but the Tribunal's decision was caused to lapse by a renewed application for discharge. The second Tribunal found that the respondent was not suffering from mental illness but should be liable for recall on the event of a relapse. The Tribunal granted a discharge with more stringent conditions than those imposed by the first Tribunal. The Health Authority and county council continued to fail to make the necessary arrangements for the respondent's release. The respondent sought a judicial review. At first instance the judge quashed the decision of the Tribunal and declared that the Health Authority and county council had erred in law in failing to make the necessary arrangements.

Held: appeal allowed. Once the Tribunal has made its decision the burden is passed to the Health Authority and local authority. The lower court had erred in blaming the Tribunal for failing to police the work of those authorities as the Tribunal had no such power. The non-compliance of the authorities would not change the lawful imposition of conditions into an unlawful decision. Providing the conditions were not irrational they were not open to judicial review and, although it may be sensible for the Tribunal to have available a care plan of workable conditions, this was not a legal requirement before imposing conditions.

9.6 Criminal and civil immunity under the MHA 1983

9.6.1 Persons acting under the authority of the MHA 1983 are granted limited immunity from liability

Section 139 of the MHA 1983

(1) No person shall be liable…to any civil or criminal proceedings to which he would have been liable apart from this section in respect of any act purporting to be done in pursuance of this Act or any regulations or rules made under this Act, or in, or in pursuance of anything done in, the discharge of functions conferred by any other enactment on the authority having jurisdiction under Pt VII of this Act, unless the act was done in bad faith or without reasonable care.

Note

This section still allows liability for negligence.

9.6.2 Legal actions must receive leave to proceed

Section 139 of the MHA 1983

(2) No civil proceedings shall be brought against any person in any court in respect of any such act without the leave of the High Court; and no criminal proceedings shall be brought…without the consent of the Director of Public Prosecutions.

Note

Leave is not required under s 139 to apply for judicial review: see *R v Hallstrom ex p W* (1985) CA.

9.7 *Reforming the MHA* (2000) Cm 5016

This is a Government White Paper which consists of two parts: The new legal framework' and 'High risk patients'. Mental disorder will be defined broadly as 'any disability or disorder of mind or brain, which results in an impairment or disturbance of mental functioning' (para 3.3). There will no longer be any requirement that the disorder be treatable and personality disorders are covered (para 3.5). New safeguards will be legislated for to ensure that compulsory powers will only be used when the person is resisting care, and treatment is either in their own best interests or necessary because he poses a

significant risk of serious harm to others. The procedure for compulsory detention is in three stages:
Stage 1—preliminary examination by two doctors and a social worker (or other suitably trained mental health professional) to determine if the patient needs further assessment or treatment by specialist mental health services without which he might be at risk of serious harm or pose a risk of serious harm to others;
Stage 2—formal assessment and initial treatment under compulsory powers. This will be limited to 28 days (para 3.38) and a formal preliminary care plan must be set out within three days (paras 3.15–3.17). Any further detention must be authorised by the new independent Mental Health Tribunal following inquisitorial procedure including representation from the patient (para 3.62) and advice from independent experts (paras 3.45–3.46);
Stage 3—care and treatment order (paras 3.49 *et seq*). The Tribunal will make an order which will authorise care and treatment specified in a care plan recommended by the clinical team, although it is unclear how far the Tribunal may amend the plan (para 3.50). The duration of the order must be specified but may be up to six months for the first two orders and subsequently for up to 12 months. The order must also state whether the patient is to be detained. If not detained the compulsory elements of the plan and the consequences of non-compliance must be specified (note: under the MHA 1983, compulsory treatment orders only apply to patients detained in hospital. The new legislation will extend this power so that orders may also be made in respect of patients cared for in the community).

The White Paper includes the Government's plans for dealing with persons with dangerous severe personality disorders. This is achieved by allowing compulsory detention of patients where treatment is necessary to obviate the serious risk of severe harm to others. To this end, the courts will also have the power to remand the person for assessment and treatment. The Government suggests that the main safeguard arises from the overseeing independent Tribunal. Additional safeguards include: free legal representation; access to independent specialist advocates; and specific provisions to cover non-consensual treatment.

10 Confidentiality and Access to Patient Records

10.1 Confidentiality

10.1.1 There is a legal obligation to respect a patient's confidence

Hunter v Mann (1974)

A police officer, acting under s 168(2)(b) of the Road Traffic Act 1972, asked the defendant for information which might have resulted in the identification of a person suspected of dangerous driving in a stolen car. The defendant was a doctor who had obtained the information solely by virtue of his professional relationship with the suspect. He refused to divulge the information on the grounds that it would be a breach of professional confidence. He was convicted in the Magistrates Court and appealed.

Held: appeal dismissed. The court accepted that the doctor owed his patients a duty of confidence but held that the duty was limited and in the circumstances the doctor's obligation of patient confidentiality was overridden by the statutory duty imposed by s 168(2)(b).

Note

The strongest basis to support a legal duty of confidence is in equity. In *Fraser v Evans* (1969), Lord Denning MR stated: 'The jurisdiction [for confidentiality] is based not so much on property or on contract as on the duty to be of good faith. No person is permitted to divulge to the world information which he has received in confidence, unless he has just cause or excuse for doing so.' In *Stephens v Avery* (1988), Sir Nicolas Browne-Wilkinson VC stated: 'The basis of equitable intervention to protect confidentiality is that it is unconscionable for a person who has received information on the basis that it is confidential subsequently to reveal that information.' That this obligation may arise from the doctor-patient relationship is clearly stated in *AG v Guardian Newspapers (No 2)* (1990), *per* Lord Keith: 'The

law has long recognised that an obligation of confidence can arise out of particular relationships. Examples are the relationships of doctor and patient, priest and penitent, solicitor and client, bank and customer.' However, the obligation may have other legal justification including, contract (*W v Edgell* (1990)), negligence (*Furniss v Flitchett* (1958)), and statute (reg 2 of the The National Health Service (Venereal Diseases) Regulations 1974). The Human Rights Act (HRA) 1998 also supports a right to confidentiality under Art 8.

10.1.2 The doctor has a professional obligation to maintain confidentiality

The GMC, *Confidentiality: Protecting and Providing Information* (2000)

(1) Patients have a right to expect that information about them will be held in confidence by their doctors. Confidentiality is central to trust between doctors and patients… If you are asked to provide information about patients you should:

(a) seek patients' consent to disclosure of information wherever possible, whether or not you judge that patients can be identified from the disclosure;
(b) anonymise data where unidentifiable data will serve the purpose;
(c) keep disclosures to the minimum necessary.

You must always be prepared to justify your decisions in accordance with this guidance.

Think point

What is the ethical justification for confidentiality?

10.1.3 The use of anonymous data will not be a breach of confidence

R v Department of Health ex p Source Informatics Ltd and Others (2000) CA

An American company wanted to gain information about doctors' prescribing habits to sell on to drug companies. The scheme they proposed was to have pharmacists collect computerised data of prescriptions. The data was anonymous in that it would not include details of the patient. The Department of Health issued a policy document stating that this would involve a breach of patient confidentiality. The company challenged the view by instigating a judicial review. The challenge was dismissed at first instance. The company appealed.

Held: appeal allowed. The concern of the law here was to protect the confider's personal privacy. The patient had no proprietary claim to the prescription form or to the information it contained. In a case involving personal confidences the confidence was not breached where the confider's identity was protected.

Note

A subsequent appeal to the House of Lord was withdrawn by the Department of Health.

Think point

Will data always be anonymous if it excludes the patients name and address?

10.1.4 The patient's consent relieves the doctor of his duty of confidence

C v C (1946)

As part of proceedings in which the petitioner was seeking a decree of nullity under the Matrimonial Causes Act 1937, the doctor treating the respondent was asked for details of the venereal disease from which she was suffering. Both petitioner and respondent signed the request for information and, had the doctor complied with the request, the respondent would have been able to make out a successful defence. The doctor refused to give the information but stated that he would if subpoenaed. This is in fact what ensued. The judge was asked to give a direction in order that a similar problem would not recur.

Held: order granted that the doctor is not justified in refusing to divulge confidential information when asked by the patient so to do.

10.1.5 The duty of confidence is not absolute and may be overridden by the public interest

W v Edgell (1990) CA

The plaintiff was imprisoned in a secure hospital following conviction for killing and other violent crimes. He made an application to a tribunal for transfer to a regional unit as a step towards release into the community. His legal advisors sought the opinion of an independent psychiatrist, Dr Edgell. Dr Edgell felt that the patient was still a danger to the public. The plaintiff's application was withdrawn. His case then fell to be automatically reviewed under s 79(1) of the Mental Health Act. Dr Edgell's report would not have

been included in the reports reviewed by the tribunal under this process. Dr Edgell felt that his report should be considered, and sent a copy to the medical director of the secure hospital and also to the Home Office. W brought an action for breach of confidence. At first instance, the court found for the defendant as the breach was justified as in the public interest. W appealed.

Held: appeal dismissed. The public interest, in ensuring that decisions that may place the public at risk are made on the basis of adequate information, outweighs the duty of confidence.

Bingham LJ stated:

> The parties were agreed, as I think rightly, that the crucial question was how, on the special facts of the case, the balance should be struck between the public interest in maintaining professional confidences and the public interest in protecting the public against possible violence… Only the most compelling circumstances could justify the doctor acting in a way which would injure the immediate interests of his patient, as the patient perceived them, without obtaining his consent.

Note

The HRA 1998 (Art 8) would require the court to consider the private interest in the doctor's duty of confidence. However, derogation under Art 8(2) is allowed in the interest of public safety and it is suggested that this would support the judgment in *W v Edgell*. In *Edgell*, the breach was justified to protect the public as a whole. There may also be a public interest in the protection of identified individuals (or groups) that would justify a breach of confidence (see, for example, *Tarasoff v Regents of the University of California* (1976) which not only held that a breach would be justified but that it would be the doctor's duty to disclose. In *Reisner v Regents of the University of California* (1995), the doctor had a duty to disclose the facts to the partner of a patient who contracted HIV from infected blood).

Think point

When does public interest justify disclosure and how should this disclosure be limited?

10.1.6 The public interest must be substantial to justify a breach of confidence

X v Y (1988)

A Health Authority employee passed on to a newspaper the names of two practising doctors being treated for AIDS. The Health Authority sought an injunction to prevent publication of the doctor's details.

Held: injunction granted.
Rose J stated:

> I keep in the forefront of my mind the very important public interest in freedom of the press. And I accept that there is some public interest in knowing that which the defendants seek to publish… But in my judgment those public interests are substantially outweighed when measured against the public interests in relation to loyalty and confidentiality both generally and with particular reference to AIDS patients' hospital records… The deprivation of the public of the information sought to be published will be of minimal significance if the injunction is granted.

10.1.7 A breach of confidence will only be justified if the information is divulged to the proper authorities or persons who need to know

Duncan v Medical Practitioners Disciplinary Committee (1986)

A bus driver underwent a triple coronary artery bypass graft operation. He was then certified fit to drive by his surgeon, His general practitioner requested that his licence be withdrawn. He also warned the bus driver's passengers of the supposed danger they faced. The Medical Practitioners Disciplinary Committee found the GP guilty of professional misconduct for a breach of confidence. The GP sought a judicial review of the decision.
Held: application refused.

Note

The New Zealand High Court accepted that public interest might justify a breach of confidentiality but, as Jeffries J stated, 'a doctor who has decided to communicate should discriminate and ensure the recipient is a responsible authority'. Thus, informing the vehicle licensing authority, when it is known that the patient will not, is likely to be justified. The GMC has detailed guidelines on this issue in Appendix 2 of their booklet on Confidentiality. It is suggested that if these guidelines were followed, the court would accept that the breach was justified unless it was made in bad faith.

10.1.8 If the information is required by law, then the disclosure will not breach any duty of confidence

Hunter v Mann (1974)

For the facts and decision, see 10.1.1.

Note

Statute law requiring the disclosure of information includes: s 18 of the Prevention of Terrorism Act 1989; reg 5 of the Abortion Regulations 1991; the notification of notifiable diseases under the Public Health Act 1984; and Misuse of Drugs (Notification of Supply to Addicts) Regulations 1973.

10.1.9 There will be no breach of confidence if the information is requested during court proceedings

Hunter v Mann (1974)

For the facts and decision, see 10.1.1.

Note

Lord Widgery CJ discussed the duty of a doctor giving evidence in court. It is clear that the doctor must respond to a question, but 'if a doctor, giving evidence in court, is asked a question…which he would normally regard as confidential, he can seek the protection of the judge and ask the judge if it is necessary for him to answer. The judge, by virtue of his overriding discretion to control his court which all English judges have, can, if he thinks fit, tell the doctor that he need not answer the question. Whether or not the judge would take that line, of course, depends largely on the importance of the potential answer to the issues being tried'. The doctor is prevented from liability for a breach of confidence because of the absolute immunity of the witness (*Watson v M'Ewan* (1905) HL). This immunity, however, would not extend to a request for information from a solicitor.

10.1.10 A right to confidentiality ceases when the patient brings a court action that necessarily requires disclosure

Hay v University of Alberta (1991)

The plaintiff brought an action for medical negligence against the hospital. He refused to consent to any discussion or consultation between the defence counsel and his doctors. The defendants applied for an order that would allow counsel to consult the plaintiff's doctors.

Held: the application would be refused, as the order would be inappropriate and unnecessary. However, the court also held that a patient's right to confidentiality ended when he begins a legal action involving the confidential matter and by bringing such an action the plaintiff's consent to disclosure can be implied.

Nicholson v Halton General Hospital NHS Trust (1999) CA

While in the defendants' employment the plaintiff developed 'radial tunnel' syndrome, which required surgical treatment. She brought an action claiming it was a work related condition. The defendant's medical expert argued that it was not work related but stated that he would need to consult the plaintiff's surgeon to discover the operative findings so that he could perfect his report. The plaintiff was advised by her counsel to refuse consent. The defendants brought an action seeking an order that the plaintiff's action should be stayed if she did not consent within a week. The order was refused and the defendants appealed.

Held: appeal allowed. Whilst there was a right to confidentiality, and it was for the plaintiff to waive that right, the court could order the plaintiff's action to be stayed if she refused consent. Order granted that the action would be stayed if the plaintiff did not consent to disclosure within two weeks.

10.1.11 The duty to respect a patient's confidence may persist after the patient's death

Re C (Adult Patient: Publicity) (1996)

The court had granted an order that life support treatment could be withdrawn from a 27 year old man in a persistent vegetative state. An order was granted to prevent identification of the patient and his family. The Official Solicitor sought guidance as to whether the order would persist after the patient's death.

Held: the order was made under s 11 of the Contempt of Court Act 1981, and would persist for as long as there were valid reasons. These reasons included: the detrimental effect on the medical staff that might happen if the order was revoked; consideration of the patient's family; the issue of medical confidentiality; and the public interest in allowing applications for withdrawal of treatment orders to be made without fear of publicity.

Note

(1) Although the case concerns a court order, the judge clearly states that the issue of medical confidentiality is at stake even after the death of the patient. Whether this would be enforceable under equity has not been tested. However, Art 8 of the HRA 1998 arguably requires that confidentiality should be maintained after death where a breach would affect the deceased's relatives right to respect for family life.
(2) The GMC (2000) states: 'You still have an obligation to keep personal information confidential after a patient dies.' A breach may incur liability for serious professional misconduct.

(3) Clearly, confidentiality after death is not absolute, however, and disclosure may be necessary to assist the coroner and complete the death certificate.

10.2 Common law remedies

10.2.1 Injunction

X v Y (1988)

For the facts, see 10.1.6.

Held: an injunction was granted to prevent the publication of confidential information.

10.2.2 Damages

Cornelius v De Taranto (2000)

The claimant contracted with the defendant doctor for a medico-legal report. Without her consent, the defendant sent copies of the report to the claimant's GP and to a consultant psychiatrist. The claimant brought an action for libel, breach of contract and breach of confidence.

Held: there was no liability for defamation. The defendant was liable for breach of confidence. It would be a 'hollow protection of the right to respect for private and family life in Art 8 of the European Convention on Human Rights if the only remedy for disclosure of details about C's private and family life in breach of confidence was nominal damages'. Although it was a novel remedy, the court was entitled to award damages in contract for injury to feelings.

Note

Although this was a case in contract, it is submitted that the same argument could be applied to a case brought in equity. In determining the level of damages to be awarded, the judge held that the material factors to be considered included: the nature and detail of the disclosure; the recipients; and the extent of disclosure together with the psychological make up of the claimant as known to the defendant.

10.3 The Data Protection Act (DPA) 1998

The DPA 1998 was passed as a result of the Data Protection Directive 1995. It replaces the DPA 1984. It provides an extra measure of protection to the common law and does not exclude a common law action for breach of confidence. It covers manual and computerised records but would not include verbal confidences that have not been recorded. Breach of the Act may amount to a criminal offence.

10.3.1 There is a statutory requirement of confidence that applies to information held in computers or manual records

Section 4 of the DPA 1998

(4) Subject to s 27(1), it shall be the duty of a data controller to comply with the data protection principles in relation to all personal data with respect to which he is the data controller.

Schedule 1, Part 1 of the DPA 1998: The Principles

(1) Personal data shall be processed fairly and lawfully and, in particular, shall not be processed unless—

(a) at least one of the conditions in Sched 2 is met; and
(b) in the case of sensitive personal data, at least one of the conditions in Sched 3 is also met.

(6) Personal data shall be processed in accordance with the rights of data subjects under this Act.

Note

Medical information counts as 'sensitive'.

Schedule 3: Conditions Relevant for the Purposes of the First Principle: Processing of Sensitive Personal Data

1 The data subject has given his explicit consent to the processing of the personal data.
2 (1) The processing is necessary for the purposes of exercising or performing any right or obligation which is conferred or imposed by law on the data controller in connection with employment.
3 The processing is necessary—
(a) in order to protect the vital interests of the data subject or another person, in a case where—

(i) consent cannot be given by or on behalf of the data subject; or

(ii) the data controller cannot reasonably be expected to obtain the consent of the data subject; or

(b) in order to protect the vital interests of another person in a case where consent by or on behalf of the data subject has been unreasonably withheld.

5 The information contained in the personal data has been made public as a result of steps deliberately taken by the data subject.

6 The processing—

(a) is necessary for the purpose of, or in connection with, any legal proceedings (including prospective legal proceedings);

(b) is necessary for the purpose of obtaining legal advice; or

(c) is otherwise necessary for the purposes of establishing, exercising or defending legal rights.

7(1) The processing is necessary—

(a) for the administration of justice;

(b) for the exercise of any functions conferred on any person by or under enactment; or

(c) for the exercise of any functions of the Crown, a Minister of the Crown or a government department.

8(1) The processing is necessary for medical purposes and is undertaken by—

(a) a health professional; or

(b) a person who, in the circumstances, owes a duty of confidentiality which is equivalent to that which would arise if that person were a health professional.

(2) In this paragraph 'medical purposes' includes the purposes of preventative medicine, medical diagnosis, medical research, the provision of care and treatment and the management of healthcare services.

10 The personal data are processed in circumstances specified in an order made by the Secretary of State for the purposes of this paragraph.

Note

Under para 10, the Secretary of State has allowed processing of sensitive data where the processing is in the 'substantial public interest' and 'must necessarily be carried out without the explicit consent of the data subject being sought so as not to prejudice those purposes' when that processing is: necessary to detect or prevent unlawful acts (para 1); necessary to protect the public against dishonesty, malpractice, improper conduct, incompetence, maladministration, etc (para 2); is necessary for the provision of confidential counselling and support (para 4); and is necessary for insurance or pension purposes (paras 5, 6). Disclosure of

information may also be allowed in connection with unlawful act, dishonesty, malpractice, improper conduct, etc, and maladministration (para 3). Processing may also be allowed: to ensure that people are given equal opportunities and treatment (para 7); in the course of legitimate political activities by registered bodies providing such processing does not (or is not likely to) cause substantial distress or damage (para 8): is in the public interest necessary and for research purposes providing it does not support decisions relating to any particular individual or cause substantial damage or distress (para 9); and where such processing is necessary for the exercise of any legitimate function of a police constable (para 10): Schedule, The Data Protection (Processing of Sensitive Personal Data) Order 2000.

10.3.2 There are a number of purposes that are granted exemption from the first principle

Part IV of the DPA 1998

Section 28 allows exemption from all the data protection principles if the data processing is required to safeguard national security. Under s 30(1), the Secretary of State may make an order exempting information relating to the physical or mental health or condition of the data subject. Section 32 allows exemption from the data protection principles (except the 7th) for journalistic, artistic or literary publication providing: s 32(b) 'the data controller reasonably believes that, having regard in particular to the special importance of the public interest in freedom of expression, publication would be in the public interest'. Importantly, s 32(1)(c) requires that 'the data controller reasonably believes that, in all the circumstances, compliance with that provision is incompatible with the special purposes'. Section 34 exempts information which the data controller is required—by or under enactment—to make public. Section 35 exempts disclosures required by law or in connection with legal proceedings.

10.3.3 Enforcement

Part V of the DPA 1998

Individual data subjects may request the Data Protection Commissioner to assess whether any data processing relating to the subject complies with the Act (s 42). In pursuance of this assessment, the controller may serve an information notice on the data controller that requires the data controller to provide the requested information (s 43). A similar power exists under s 44 for information relating to the 'special purposes' of journalistic, literary or artistic publication. If the Commissioner is satisfied that the data controller is

contravening the Act, then s 40(1) allows the Commissioner to serve an enforcement notice on the data controller. The enforcement notice may require the data controller to take steps to rectify the contravention or to refrain from any continued contravention. Under s 47(1), a failure to comply with a notice is an offence although there is the right of appeal to a tribunal (s 48). Conviction of an offence is punishable by a fine.

10.3.4 Compensation

Section 13 of the DPA 1998

(1) An individual who suffers damage by reason of any contravention by a data controller of any of the requirements of this Act is entitled to compensation from the data controller for that damage.
(2) An individual who suffers distress by reason of any contravention by a data controller of any of the requirements of this Act is entitled to compensation from the data controller for that distress if—

  (a) the individual also suffers damage by reason of the contravention; or
  (b) the contravention relates to the processing of processing data for the special purposes [of journalistic, literary or artistic publication].

(3) In proceedings brought against a person by virtue of this section, it is a defence to prove that he had taken such care as in all the circumstances was reasonably required to comply with the requirement concerned.

10.4 Patient access to personal information

10.4.1 Patients have a right to access personal data

Section 7 of the DPA 1998

(1) Subject to the following provisions of this section and to ss 8 and 9, an individual is entitled—

  (a) to be informed by any data controller whether personal data, of which that individual is the data subject, are being processed by or on behalf of that data controller; .
  (b) if that is the case, to be given by the data controller a description of—

    (i) the personal data of which that individual is the data subject;
    (ii) the purposes for which they are being or are to be processed; and
    (iii) the recipients or classes of recipients to whom they are or may be disclosed;

(c) to have communicated to him in an intelligible form—

(i) the information constituting any personal data of which that individual is the data subject; and
(ii) any information available to the data controller as to the source of those data…

Note

The data controller is only obliged to comply where he can be sure of the identity of the person requesting the information (s 7(3)). Also, if complying with the request would result in disclosure of information relating to a third party, the data controller need not comply unless that third party consents or it is reasonable to comply without the third party's consent (s 7(4)).

10.4.2 The data controller need not comply with s 7 of the DPA 1998 if compliance would cause serious harm

Data Protection (Subject Access Modification) (Health) Order 2000

5(1) Personal data to which this Order applies are exempt from s 7, in any case, to the extent to which the application of that section would be likely to cause serious harm to the physical or mental health or condition of the data subject or any other person.

Note

This only applies to information relating to the physical or mental health or condition of the patient (Art 3(1)). The exemption only applies if the data controller is the health professional that currently or most recently was responsible for the patient, or after the data controller has consulted such a health professional (Art 5(2)).

10.4.3 There is no absolute right of access to medical records

R v Mid-Glamorgan FHSA ex p Martin (1995) CA

The applicant had repeatedly made requests for access to his health records. The records had all been made prior to 1991 and were therefore not subject to the statutory right of access under the Access to Health Records Act 1990 or the DPA 1984. Access was refused on the grounds that disclosure might be detrimental to the applicant who had a history of psychological problems, although they offered to disclose the records to the applicant's current medical adviser for him to consider whether the information might harm the

applicant. At first instance, the judge held there was no common law right of access nor was there any breach of Art 8 of the European Convention for the Protection of Human Rights. The applicant appealed.

Held: appeal dismissed. A health authority could deny a patient access to his medical records if it was in the patient's best interests to do so.

Nourse LJ stated:

> A doctor, likewise a health authority, as the owner of a patient's medical records, may deny the patient access to them if it is in his best interests to do so, for example, if their disclosure would be detrimental to his health…the doctor's general duty, likewise the health authority's, is to act at all times in the best interests of the patient. Those interests would usually require that a patient's records should not be disclosed to third parties; conversely, that they should usually be handed on by one doctor to the next or made available to the patient's legal advisers if they are reasonably required for the purposes of legal proceedings in which he is involved.

Note

In *Breen v Williams* (1995), the Australian Supreme Court of New South Wales held that there was no common law right of access to medical records and this included any claims to rights of access in equity. Also, the Code of Practice on Openness in the NHS 1995 requires healthcare professionals to release a patient's record at their request even where they pre-date the code. This is, however, a non-statutory code but is enforceable by the Health Service Commissioner.

10.4.4 There is a statutory right of access to the patient's notes after the patient's death

Section 3 of the Access to Health Records Act 1990

(1) An application for access to a health record, or to any part of a health record, may be made to the holder of the record…—

(f) where the patient has died, [by] the patient's personal representative and any person who may have a claim arising out of the patient's death.

Note

The other persons who may have sought access under this Act must now seek access under the Data Protection Act 1998, which repealed sub-ss (a)–(e) of this section.

10.4.5 There is a statutory right of access to employment or insurance medical reports

Section 1 of the Access to Medical Reports Act 1988

It shall be the right of an individual to have access, in accordance with the provisions of this Act, to any medical report relating to the individual which is to be, or has been, supplied by a medical practitioner for employment purposes or insurance purposes.

Note

the patient may ask the record holder to correct any inaccuracies (s 5) and the record holder must either do so or note the patient's allegations concerning the disputed information. Section 7 allows the medical practitioner to withhold access if he believes that disclosure would 'be likely to cause serious harm to the physical or mental health of the individual or others'. Before any report may be made, the consent of the patient must be sought and the patient must be informed of his rights of access, consent and amendments (s 3).

10.5 Flow of patient information

The Health and Social Care Bill 2001 contains a number of provisions relating to the flow of patient information. The Secretary of State may make regulations prohibiting (s 59(1)), requiring or regulating (s 59(3)) the processing of patient information. Where information processing is required it must be either 'in the interests of improving patient care' (s 59(3)(a)) or 'in the public interest' (s 59(3)(b)). It should be noted that the regulations may not be made 'solely or principally for the purpose of determining the care and treatment to be given to particular individuals' (s 59(7)). The regulations must be consistent 'with any provision made by or under the Data Protection Act 1998' (s 59(8)), and before making any such regulation, the Secretary of State must 'consult such bodies appearing to him to represent the interests of those likely to be affected by the regulations as he considers appropriate' (s 59(9)).

11 Patient's Rights

There is no specific legal instrument that provides the patient with enforceable rights. The Patient's Charter has no legal force and it is better to see the document as setting the standards that the NHS should aspire towards. More importantly, although not specific to healthcare, the Human Rights Act 1998 (HRA) came into force on 2 October 2000. This provides that a number of rights, previously protected by the European Convention on Human Rights, will be incorporated directly into English Law. This chapter will describe the rights that will be most applicable to healthcare. For a fuller discussion of the HRA, see the relevant references in the suggested reading list. The issues of confidentiality and the right to refuse treatment have already been dealt with. The other area in which patients' rights have been explored is in the provision of healthcare.

11.1 The provision of healthcare

11.1.1 The government has accepted a political obligation to protect health and provide medical assistance

European Social Charter 1961 (revised 1996)

Article 11—The right to protection of health

With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organisation, to take appropriate measures designed *inter alia:*

(1) to remove as far as possible the causes of ill health;
(2) to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
(3) to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

Article 13—The right to social and medical assistance

With a view to ensuring the effective exercise of the right to social and medical assistance, the Contracting Parties undertake:

(1) to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources…be granted…in case of sickness, the care necessitated by his condition.

Note

These rights are only of political importance and are not legally enforceable by individuals.

11.1.2 The Secretary of State is under a duty to provide a comprehensive health service that can meet all reasonable requirements

National Health Service Act 1977

s 1 (1)—It is the Secretary of State's duty to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement—

(a) in the physical and mental health of people of those countries; and
(b) in the prevention, diagnosis and treatment of illness.

s 2 —Without prejudice to the Secretary of State's powers apart from this section, he has power—

(a) to provide such services as he considers appropriate for the purpose of discharging any duty imposed on him by this Act; and
(b) to do any other thing whatsoever which is calculated to facilitate, or is conducive or incidental to, the discharge of such a duty.

s 3 (1)—It is the Secretary of State's duty to provide throughout England and Wales, to such extent as he considers necessary to meet all reasonable requirements—

(a) hospital accommodation;
(b) other accommodation for the purpose of any service provided under this Act;
(c) medical, dental, nursing and ambulance services;
(d) such other facilities for the care of expectant and nursing mothers and young children as he considers are appropriate as part of the health service;
(e) such facilities for the prevention of illness, the care of person's suffering from illness and the after care of person's who have suffered from illness as he considers are appropriate as part of the health service;
(f) such other services as are required for the diagnosis and treatment of illness.

11.1.3 The Secretary of State's duty is not absolute and is constrained by the resources available

R v Secretary of State for Social Services, West Midlands RHA and Birmingham AHA (Teaching) ex p Hincks (1987) CA

The Secretary of State had previously approved plans for additional orthopaedic services. Because of a lack of money, the plans were put on hold for 10 years. The applicants claimed that the provision of health services in their area was insufficient and the decision to shelve the plans was a breach of the Secretary of State's duty under s 3(1) of the NHS Act 1977. This was refused at first instance and the applicants appealed.

Held: s 3(1) does not impose an absolute duty. The Secretary of State is only obliged to do what he can with the resources available to him. His duty is to the country as a whole rather than to a particular hospital department.

Bridge LJ stated:

> The limitation [on the Secretary of State's duty] must be determined in the light of current government economic policy. I think that it is quite clearly an implication which must be read into s 3(1) of the National Health Service Act 1977 if it is to be operated realistically… I only hope that…[the applicants] have not been encouraged to think that these proceedings offered any real prospects that this court could enhance the standards of the National Health Service, because any such encouragement would be based upon manifest illusion.

Note

In *R v North and East Devon HA ex p Coughlan*, Sedley LJ stated: 'The truth is that, while [the Secretary of State] has a duty to continue to promote a comprehensive free health service and he must never, in making a decision under s 3, disregard that duty, a comprehensive health service may never, for human, financial and other resource reasons, be achievable.'

11.1.4 Patients may challenge the allocation of resources by judicial review

R v Central Birmingham HA ex p Walker; R v Secretary of State for Social Services ex p Walker (1987) CA

A premature baby required an operation to repair a 'hole in the heart'. The operation had been cancelled several times because of a shortage of nurses but the child's life was not in any immediate danger. The child's mother

applied for a judicial review of the Health Authority's decision. At first instance the judge held that it was impossible to say that there was any substantive or procedural illegality in the decision. The applicant appealed.

Held: the court would not substitute its own judgment for the judgment of those responsible for the allocation of resources unless the allocation was *Wednesbury* unreasonable. The jurisdiction to intervene did exist but leave would be refused in this case.

Note

(1) Sir John Donaldson, in *ex p Walker*, commented that the jurisdiction to review resource allocation should be 'used extremely sparingly'. The difficulty in challenging resource allocation is illustrated by *ex p B* (below).
(2) Generally, a public body's decision does not have to be the best possible decision, although it should be responsible. It may be challenged by judicial review where the decision is:
    (a) illegal;
    (b) procedurally flawed (see *R v Secretary of State for Health ex p Pfizer* (1999), in which the court held that while the Secretary of State could make a policy decision to restrict prescription of Viagra, this should be done through the proper channels and not simply by issuing an advisory circular); or
    (c) irrational. Irrationality was defined in *Associated Provincial Picture Houses v Wednesbury Corp* (1948) as a decision 'so unreasonable that no reasonable authority could ever have come to it'. This was restated by Lord Diplock, in *Council of Civil Service Unions v Minister for the Civil Service* (1985) as 'so outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question to be decided could have arrived at it'. This is, in practice, such an insurmountable test that some authors have described resource allocation as non-justiciable (see O'Sullivan (1998)). The test is likely to be changed to one of 'proportionality' by the HRA (see below).

R v Cambridge DHA ex p B (1995) CA

B was a 10 year old girl suffering from leukaemia. She had already received extensive treatment, including a bone marrow transplant. The doctors treating her were of the opinion that any further treatment would not be helpful. Her father obtained a second opinion that suggested a further course of chemotherapy with a success rate of 10–20% and a further bone marrow transplant—with a similar success rate—might be undertaken. The Health

Authority refused to fund the treatment, because the treatment: (1) would cause the child suffering and would not be in her best interests; and (2) would not be an effective use of resources. Her father sought a judicial review. At first instance the application was allowed and the decision quashed since the child's right to life was threatened and the Authority could not infringe this right unless it could show substantial justification on public interest grounds. The Health Authority appealed.

Held: appeal allowed.

Sir Thomas Bingham MR stated:

> Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of a maximum number of patients. This is not a judgment which the court can make.

Think point

How will the HRA 1998 affect the way courts consider issues such as resource allocation?

11.1.5 Where a public body has a statutory duty to meet the needs of particular individuals, it may not take resources into consideration

R v Gloucestershire CC ex p Barry (1996) CA

The council decided to give greater priority to the seriously disabled following the withdrawal of a government grant. This applicant's needs were not reassessed in light of the decision and they were informed by a standard form letter. The applicants applied for judicial review. The first instance judgment split the process into two stages: the discretionary assessment stage in which resources might be considered; and the provision of arrangements based on the assessment in which resources were irrelevant. The applicant appealed against the High Court's decision that, in assessing or reassessing a disabled person's needs under s 2(1) of the Chronically Sick and Disabled Persons Act 1970, the council could take account of the resources available.

Held: a local authority was not entitled to take resources into account when performing its duty (under s 2(1) of the Chronically Sick and Disabled Persons Act 1970) of determining whether it should make arrangements to meet the needs of a disabled person as set out in that section. Once the needs of a disabled person were identified, resources might be taken into account when considering how to meet those needs.

Note

This decision is restricted to those duties to provide for an individual's *needs*. Where an arrangement is simply *desirable*, then resources may be considered when making the assessment. Swinton LJ used s 29 of the National Assistance Act 1948 and s 47(1) of the National Health Service and Community Care Act 1990 as examples of when it would be proper to take resources into account.

11.1.6 A health authority must take national policy into account when allocating resources

R v North Derbyshire HA ex p Fisher (1997)

The applicant, who suffered from multiple sclerosis, was considered by a consultant neurologist to be suitable for a course of beta-interferon. The Trust responsible for his care declined to fund the treatment as their policy, because of a lack of resources, was only to fund those patients involved in a national clinical trial. This policy was contrary to an NHS Circular, which stated: 'Where the treatment with beta-interferon is appropriate, it is suggested that treatment should be initiated and the drug prescribed by the specialist.' The applicant sought a judicial review of the Trust's decision.

Held: the NHS circular was not mandatory but sought only to provide guidance. However, although it was not mandatory, the Trust should at least have taken the guidance into account. Since the Trust had entirely disregarded the circular, their policy was unlawful. The Trust was ordered to formulate and implement a new policy to take account of the circular.

Dyson J stated:

> [The Trust] knew that their own policy amounted to a blanket ban on beta-interferon treatment. A blanket ban was the very antithesis of national policy, whose aim was to target the drug appropriately at patients who were most likely to benefit from treatment.

11.1.7 Where an authority creates a legitimate expectation of substantial benefit, any decision that frustrates that expectation may be so unfair as to be an abuse of power

R v North and East Devon HA ex p Coughlan (1999) CA

The appellant was tetraplegic and permanently resident in a purpose built NHS facility. When she was originally transferred to Mardon House, it was on the express promise that it would be her home for as long as she wished. The NHS drew a distinction between 'general' and 'specialist' nursing

services. Following guidance, from the Secretary of State, delineating the division of responsibility between the NHS and social services the Health Authority reviewed the care options for the appellant and other patients. The review concluded that they did not meet the eligibility criteria for NHS care and the Health Authority subsequently decided to close Mardon House without detailing any provisions for the provision of alternative care. The appellant applied for judicial review and the Health Authority's decision was quashed by the judge at first instance. The Health Authority appealed.

Held: appeal dismissed. Amongst other grounds, the Court of Appeal held that the appellant had a legitimate expectation that the Health Authority would provide for her care at Mardon House. A legitimate expectation arises from a lawful promise of an important benefit limited to a few individuals. Where a public body treats the individual contrary to this expectation, there are three possible outcomes:

(a) the court may decide that the authority is only required to bear in mind its previous policy or representation, giving it the weight it thinks right. There the court is confined to review on *Wednesbury* grounds;
(b) the court may decide that the promise or practice induces a legitimate expectation of being consulted, and the court will require an opportunity for consultation to be given unless there is an overriding reason to resile from it, when the court itself will judge the adequacy of the reason advanced for the change in policy;
(c) where the court decides that a lawful promise or practice has induced a legitimate expectation of a substantive benefit, the court will in a proper case decide whether to frustrate the expectation is so unfair that to take a new course will amount to an abuse of power.

In such circumstances the court is not restricted to reviewing the decision on *Wednesbury* grounds. In the present case fairness required the Health Authority not to resile from their promise, since there was no overriding justification, and the Health Authority's failure to weigh the conflicting interests correctly, was unfair and an abuse of power.

11.1.8 It is unlawful to operate a blanket ban that makes no allowance for the clinical need of the individual

North West Lancashire HA v A, D & G (1999) CA

The respondents were transsexuals seeking gender reassignment treatment and surgery. The Health Authority refused to fund the treatment based on its policy to assign a low priority for funding to a number of procedures it considered to be ineffective in producing a health gain. Gender

reassignment surgery was one of the procedures listed for which—apart from general psychiatric and psychological services—the Authority would not provide a service apart from in exceptional circumstances or where there was an overriding clinical need. At first instance, a order was granted quashing the Health Authority's decision and its policy. The Authority appealed.

Held: appeal dismissed. In prioritising life threatening and serious illness, the precise allocation of resources is a matter for the Health Authority and not the court. However, the Authority must 'accurately assess the nature and seriousness of each type of illness…determine the effectiveness of various forms of treatment for it; and…give proper effect to that assessment and that determination in the formulation and individual application of its policy'. The Authority's policy was flawed because it did not treat transsexualism as an illness and, because it did not believe in such a treatment for the condition, its policy effectively amounted to a blanket ban.

11.1.9 A decision will be unlawful if it discriminates against persons on grounds which are protected by law

R v Ethical Committee of St Mary's Hospital (Manchester) ex p Harriott (1988)

The applicant sought judicial review of a decision that rejected her application for IVF treatment because she was unsuitable. She had a criminal record for prostitution and had already been rejected by the adoption agencies she had applied to.

Held: application refused. The Committee's policy would have been unlawful had it decided to 'refuse all such treatment to anyone who was a Jew or coloured'.

Note

Policies that discriminate on the basis of colour or race will contravene the Race Relations Act 1976. Similarly, discrimination between the sexes or on the basis of marital status may contravene the Sex Discrimination Act 1975. The Disability Discrimination Act 1995 prohibits discrimination on the grounds of disability.

Think point

Consider how resources might be fairly allocated. What is this type of justice called and what factors should be taken into account?

11.2 The Human Rights Act 1998

The Human Rights Act (HRA) 1998 came into force on 2 October 2000. It has incorporated the bulk of the rights protected by the European Convention on Human Rights. While this is not a text on human rights, it is worth noting some of the main implications for healthcare law. Also, the judgments, although sparse at the moment, have begun to proclaim on the human rights issues in healthcare. The most important changes that the HRA brings are:

(1) that individuals will now be able to challenge public bodies directly in the domestic court when their protected human rights have been breached. Individuals will no longer have to exhaust all the domestic provisions and then make the slow and expensive trip to Strasbourg in order to claim a breach of one of their rights;
(2) that human rights issues may be raised in all cases and not just those where a direct challenge is available;
(3) the judicial scrutiny of decisions made by public bodies will become more rigorous and the emphasis will shift away from the duty of the public body to the right of the individual. The change is succinctly summarised by the Lord Chancellor, Lord Irvine (1998), who stated: 'The court's decisions will be based on a more overtly principled, and perhaps moral, basis. The Court will look at the positive right. It will only accept an interference with that right where a justification, allowed under the Convention, is made out. The scrutiny will not be limited to seeing if the words of an exception can be satisfied. The Court will need to be satisfied that the spirit of this exception is made out. It will need to be satisfied that the interference with protected right is justified in the public interests in a free democratic society. Moreover, the courts will in this area have to apply the Convention principle of proportionality. This means the Court will be looking substantively at that question. It will not be limited to a secondary review of the decision making process but at the primary question of the merits of the decision itself.' Proportionality will replace the previous test of *Wednesbury* 'unreasonableness' (see 11.1.4). It has three elements: (1) there must be a legitimate aim, for example, the protection of public health; (2) it must be necessary, that is, it could not be achieved by a means less invasive of individual rights; and (3) the degree of infringement of the individual's right must be justified and no greater than is necessary to achieve the legitimate aim;
(4) under s 3(1) of the HRA 1998: 'So far as it is possible to do so, primary legislation and subordinate legislation must be read and given effect in a way which is compatible with the Convention rights.'

11.3 The rights relevant to healthcare protected by the Human Rights Act 1998

11.3.1 Article 2—Right to life

(1) Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court…

Note

(1) The meaning of 'Everyone' has been considered prior to the Act coming into force. In *Re MB*, it was decided that the fetus was certainly not protected prior to viability, and probably was not protected at all by Art 2 (for one of the Convention decisions see, for example, *Paton v UK* (1980)). Thus, abortion does not contravene the HRA 1998 and pregnant women still have the right to refuse treatment even if it results in the death of the fetus.
(2) There is an argument that Art 2 might allow an individual the right to demand life saving treatment. However, there is no case law (but see below) directly on the subject and any such right would be constrained by resources (see *Osman v UK* (2000)), and would be negated if the treatment was likely to be futile (see *LCB v UK* (1998)). Given these factors and the judicial reluctance to direct a doctor to treat against his clinical judgment, the case for a right to life saving treatment is strongest when the treatment is being withheld for reasons that unfairly discriminate against the individual.
(3) Withdrawal or withholding of treatment will not breach Art 2, providing it is not contrary to the individual's best interests.

NHS Trust A v Mrs M; NHS Trust B v Mrs H (2000)

M and H were both diagnosed as being in a persistent vegetative state. The Trusts sought a declaration that it would be lawful to withdraw treatment.

Held: declaration granted. The analysis in *Airedale NHS Trust v Bland* was compatible with the HRA 1998.

Butler-Sloss P stated:

> An omission to provide treatment by the medical team will, in my judgment, only be incompatible with Art 2 where the circumstances are such as to impose a positive obligation on the State to take steps to prolong a patient's life.

She later continued:

> Article 2 therefore imposes a positive obligation to give life sustaining treatment in circumstances where, according to responsible medical opinion, such treatment is in the best interest of the patient but does not impose an absolute obligation to treat if such treatment would be futile.

Note

This would agree with the judgment in *A NHS Trust v D* (2000), decided just before the HRA came into force. Cazalet J granted a declaration that the doctors did not need to treat a severely disabled child with artificial ventilation. He stated: 'there can be no Art 2 infringement here because the treatment as advised is, in light of the order I propose to make, in the best interests of I'.

Think point

When would it be in the patient's best interest to die? Does this apply to patients in PVS?

11.3.2 Article 3—Prohibition of torture

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

Note

(1) At first sight, it might seem odd to include this right as relevant to healthcare. However, it has been held that a failure to provide a prisoner with medical care could be sufficiently degrading as to breach Art 3 (see *Hurtado v Switzerland* (1994)). Non-consensual treatment may also breach this right unless it 'is necessary from the medical point of view and carried out in conformity with standards accepted by medical science' (*Herczegfalvy v Austria* (1992)). The degree of ill-treatment necessary has been defined as treatment which 'lowers the rank, position, reputation or character, whether in his own eyes or the eyes of other people' (see *East African Asians v UK* (1981)). This would include failure to care sufficiently for a patient's hygiene, comfort and dignity; leaving patient's for prolonged periods in corridors, for example, might breach this article. More contentiously, it may also be argued that using quality of life decisions to deny persons clinically effective treatment might breach Art 3. However, in *North West Lancashire HA v A, D & G,* the court held that Art 3 imposed no obligation to provide free healthcare. This does not mean that the refusal of treatment would never breach Art 3 (see above) since this case involved gender reassignment surgery and was therefore not a matter of life and death. Also, the applicants were not completely prevented from receiving the treatment since they were free to seek the treatment privately. Whether the refusal to provide potentially life saving treatment is capable of breaching this Article remains to be seen, but an applicant's case would be further strengthened if there was no

realistic opportunity for them to obtain the treatment except through the public body.

(2) On the other hand, Art 3 may also provide further justification for not treating patients with minimally effective treatments that are inherently painful or degrading. Thus, in *A NHS Trust v D*, Cazalet J stated: '…in *D v UK* [1997] 24 EHRR 423 it was held that Art 3 of the Convention…includes the right to die with dignity.'

(3) Although her argument is open to criticism, in *NHS Trust A v Mrs M; NHS Trust B v Mrs H*, Butler-Sloss P stated: 'Article 3 requires the victim to be aware of the inhuman and degrading treatment which he or she is experiencing or at least to be in a state of physical or mental suffering. An insensate patient suffering from permanent vegetative state has no feelings and no comprehension of the treatment accorded to him or her. Article 3 does not in my judgment apply.'

(4) Remember that this right allows no derogation and therefore resources are not relevant. However, the European Commission has held that, providing it acts in the 'best interests' of the individual, the State's obligations under Art 2 may outweigh that individual's rights under Art 3: *X v FRG* (1984).

Think point

Can someone be treated in a degrading manner if they are unaware of the treatment?

11.3.3 Article 5—Right to liberty and security

(1) Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants.

(4) Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

(5) Everyone who has been the victim of arrest or detention in contravention of the provisions of this Article shall have an enforceable right to compensation.

Note

This article will be most relevant to detention of patients under the auspices of the Mental Health Act (MHA) 1983.

11.3.4 Article 6—Right to a fair trial

(1) In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law.

Note

Again, this may be relevant to patients detained under the MHA 1983. Also, this article will be breached where, for example, declarations are sought and a failure to follow the correct procedure results in an *ex parte* hearing without the opportunity for the patient to be properly represented: *St Georges Healthcare NHS Trust v S; Rv Collins and Others ex p S* (1998) CA.

11.3.5 Article 8—Right to respect for private and family life

(1) Everyone has the right to respect for his private and family life, his home and his correspondence.
(2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

Note

(1) It is arguable that this right allows the individual the right to be informed about decisions that affect his life. Prior to the HRA 1998, there was no legal obligation for patients to be informed about decisions not to offer a particular treatment. 'Do not resuscitate' orders could be lawfully made and entered into the patients' notes without any consultation (although this practice may breach professional ethics). The protection afforded by Art 8 means that patients (or their parents in the case of children) should be consulted over these decisions. (This follows by analogy from *W v UK* (1987), which involved the right of parents to be involved in decisions concerning children taken into care. The ECHR stated: 'In the Court's view, what therefore has to be determined is whether, having regard to the particular circumstances of the case and notably the serious nature of the decisions to be taken, the parents have been involved in the decision making process…to a degree sufficient to provide them with the requisite protection of their interests.') There may arguably be a case that the next of kin or

nearest relatives of incompetent adult patients should also be consulted.

(2) It is unlikely that Art 8 will allow either the patient or the patient's relatives a right to demand a particular treatment. Thus, in *North West Lancashire HA v A, D & G*, the Auld LJ stated: 'Article 8 imposes no positive obligation to provide treatment.' On the other hand, where the Health Authority has created a legitimate expectation for the provision of a resource, then Art 8 may make it unlawful for the Authority to subsequently withdraw that resource. Thus, in *R v North and East Devon HA ex p Coughlan* (see 11.1.7), withdrawing the provision of specialist nursing home accommodation without providing a suitable alternative was held to be a breach of Art 8. Whether this might apply to other resources, such as kidney dialysis, etc, is not certain.

11.3.6 Article 9—Freedom of thought, conscience and religion

(1) Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.

(2) Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

Think point

What are the implications of this Article for healthcare practice?

11.3.7 Article 14—Prohibition of discrimination

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

Note

There are two important things to note. First, this Article only comes into play if one of the other protected rights is also being breached. Second, discrimination on any ground is prohibited. The examples given are not exhaustive and other grounds that may be particularly relevant to healthcare are discrimination on the basis of age or postcode.

12 Medical Negligence

Medical negligence costs for the financial year 1990–91 were around £50 m. A recent analysis of the records from within one health authority has estimated that the rate of litigation increased from 0.46 to 0.81 closed claims per 1,000 completed consultant episodes. This represents an estimated cost to the NHS of £84 m (not including administrative and in-house legal costs), which is one-quarter of 1% of the annual cost of the NHS: Fenn *et al* (2000). In the recent report from the National Audit Office (2001), the cost of outstanding claims—as at 31 March 2000—was estimated to be £2.6 billion with an additional cost of £1.3 billion for negligent events that have not yet been claimed for. As with ordinary negligence, the elements of medical negligence are: duty of care, breach of duty and damage.

12.1 Duty of care

12.1.1 A doctor owes a duty of care to anyone he accepts as a patient

Pippin v Sheppard (1822)

The defendant surgeon treated the injuries and wounds of the plaintiff. The treatment was careless and the plaintiffs wound became inflamed and more painful. Her life was also endangered and she had to undergo further treatment by other surgeons.

Held: it was not relevant who retained or employed the surgeon, but was enough that he had treated the plaintiff. It was also unnecessary for the plaintiff's declaration to allege that the surgeon owed a duty or that he had undertaken to treat the plaintiff skillfully.

Edgar v Lamont (1914) Court of Session

The defendant was called upon to treat the plaintiff's cut finger. After two weeks of treatment she had to have the finger amputated. She sued the defendant in negligence. The defendant argued that the action should have been for breach of contract and his contract was with the plaintiff's husband and not the plaintiff.

Held: it was irrelevant who was going to pay the bill; a doctor owes a duty of care to his patient.

Note

In *R v Bateman* (1925)—a manslaughter case—the court stated: 'If a doctor holds himself out as possessing special skill and knowledge, and he is consulted as possessing such skill and knowledge, by or on behalf of the patient, he owes a duty to the patient to use caution in undertaking the treatment.'

12.1.2 The doctor is under no legal obligation to treat a person who is not his patient

F v West Berkshire HA (1989)

For the facts and decision, see 3.2.2 and 3.4.1.

Lord Goff stated:

> The 'doctor in the house' who volunteers to assist a lady in the audience who, overcome by the drama or by the heat in the theatre, has fainted away is impelled to act by no greater duty than that imposed by his own Hippocratic oath.

Note

There may be professional obligations to assist strangers involved in accidents; see GMC (1998), para 4, which states: 'In an emergency, you must offer anyone at risk the treatment you could reasonably be expected to provide.' See, also, UKCC (1996).

12.1.3 GPs are under a statutory duty to treat emergencies within their practice area

Schedule 2 to the National Health Service (General Medical Services) Regulations 1992

(4) (1) By virtue of his contract with the FHSA, a GP must assist:

(h) persons to whom he may be requested to give treatment which is immediately required owing to an accident or other emergency at any place in his practice area, provided that—

(i) he is not, at the time of the request, relieved of liability to give treatment under para 5 (if the doctor is elderly or infirm); and

(ii) he is not, at the time of the request, relieved under para 19(2) (if another doctor is already present), of his obligation to give treatment personally; and

(iii) he is available to provide such treatment.

12.1.4 A doctor may owe a duty of care to third parties who are not his patient, if injury is reasonably foreseeable

Tredget v Bexley HA (1994)

The plaintiffs watched their newborn child deteriorate and die 48 hours after the negligent delivery of their child by the defendants. They subsequently suffered from psychiatric illness.

Held: the defendants were liable to both the father and mother of the child.

Thake v Maurice (1986) CA

The plaintiff husband underwent a vasectomy. The defendant failed to warn either of the plaintiffs (husband and wife) of the risk that the vasectomy would fail to sterilise Mr Thake. The plaintiff wife subsequently became pregnant. They sued the defendant in both negligence and contract.

Held: the failure to warn of the risk of failure was a breach of the surgeon's duty of care that he owed to both the husband and his wife.

12.1.5 A doctor will not owe a duty of care to third parties if they are not identifiable at the time of the breach

Goodwill v British Pregnancy Advisory Service (1996) CA

M had a vasectomy performed by the defendants. He was informed that the operation had been successful and that he would no longer need to use contraception to avoid pregnancy. The plaintiff, who was not M's partner at the time of the operation, began a sexual relationship with M. She subsequently became pregnant and sued the defendants.

Held: there was no liability. The relationship between the doctors and the future sexual partners of a man undergoing a vasectomy was not sufficiently close to establish a duty of care.

Gibson LJ applied the principles established in *Hedley Byrne* and stated:

> I cannot see that it can properly be said of the defendants that they voluntarily assumed responsibility to the plaintiff when giving advice to Mr MacKinlay. At that time they had no knowledge of her, she was not an existing sexual partner of Mr MacKinlay but was merely, like any other woman in the world, a potential future sexual partner of his, that is to say, a member of an indeterminately large class of females who might have sexual relations with Mr MacKinlay during his lifetime.

12.1.6 There is no doctor-patient relationship between a doctor and the relatives of his patient

Powell v Boldaz (1997) CA

A young boy in the care of the defendants died after the defendants failed to diagnose that the boy was suffering from Addison's disease. The action for negligence, in failing to diagnose the disease, and the claim for damages for psychiatric illness suffered by the boy's mother as a result of his death were settled. The plaintiffs, however, further alleged that following R's death, the defendants had attempted to cover up their negligence and that this had caused the first plaintiff psychiatric injury and had exacerbated the second plaintiff's psychiatric complaints. They brought a claim for injury and economic loss based on the events after their son's death. The claims were struck out at first instance and the plaintiffs appealed.

Held: appeal denied. A doctor-patient relationship is not established between the doctor and his patient's relatives when the doctor tells his patient's relatives that the patient has died. There was no freestanding duty of candour, irrespective of the doctor/patient relationship.

Smith LJ stated:

> I do not think that a doctor who has been treating a patient who has died, who tells relatives what has happened, thereby undertakes the doctor-patient relationship towards the relatives. It is a situation that calls for sensitivity, tact and discretion, but the mere fact that the communicator is a doctor, does not, without more, mean that he undertakes the doctor-patient relationship.

Think point

How might this case have been decided if the Human Rights Act 1998 had been in force?

12.2 Liability of hospitals

12.2.1 Hospitals will be vicariously liable for the negligence of their employees

Collins v Hertfordshire CC (1947)

The night before an operation to remove an extensive growth from the jaw of the plaintiff's husband, the house surgeon (a final year medical student) took an order over the phone from the visiting surgeon. The house surgeon misheard the order and obtained a solution of cocaine and

adrenaline instead of procaine and adrenaline. The surgeon failed to check the label and administered a dose of the solution that killed the plaintiff's husband.

Held: the hospital was vicariously liable for the actions of the house surgeon as their employee. The hospital was not liable for the negligence of the visiting surgeon.

NHS Indemnity: DoH (1996)

Main principles

NHS bodies are vicariously liable for the negligent act and omissions of their employees and should have arrangements for meeting this liability.

NHS Indemnity applies where:

(a) the negligent healthcare professional was:

(i) working under a contract of employment and the negligence occurred in the course of that employment;
(ii) not working under a contract of employment but was contracted to an NHS body to provide services to persons to whom that NHS body owed a duty of care;
(iii) neither of the above but otherwise owed a duty of care to the persons injured;

(b) persons, not employed under a contract of employment and who may or may not be a healthcare professional, who owe a duty of care to the persons injured. These include locums; medical academic staff with honorary contracts; students; those conducting clinical trials; charitable volunteers; persons undergoing further professional education, training and examinations; students and staff working on income generation projects.

Where these principles apply, NHS bodies should accept full financial liability where negligent harm has occurred, and not seek to recover their costs from the healthcare professional involved.

12.2.2 The hospital may also be directly liable for failing to provide a reasonable system of care

Bull v Devon AHA (1993) CA

The plaintiff was a woman who had presented with a twin pregnancy. After the first twin was born, the junior doctor called for urgent assistance from a senior colleague. The hospital operated a split site and the other doctor was in the gynaecology department over one mile away from the obstetric unit. It took over an hour for him to arrive and the second twin was born with severe brain damage.

Held: the Health Authority was negligent because of its failure to provide and implement an efficient system of care.

Cassidy v Ministry of Health (1951) CA

The plaintiff underwent an operation for a contraction deformity of the third and fourth fingers of his left hand. The operation made his situation worse by causing his two unaffected fingers to become stiff making his hand almost completely useless.

Held: the defendants were liable for negligence.

Denning LJ stated:

> In my opinion, authorities who run a hospital, be they local authorities, government boards, or any other corporation, are in law under the self-same duty as the humblest doctor. Whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment.

Note

See, also, Lord Greene MR's judgment in *Gold v Essex County Council* (1942): '…if the obligation is undertaken by a corporation, or a body of trustees or governors, they cannot escape liability for its breach any more than an individual can; and it is no answer to say that the obligation is one which, on the face of it, they could never perform themselves… I cannot myself see any sufficient ground for saying that the respondents do not undertake towards the patient the obligation of nursing him as distinct from the obligation of providing a skilful nurse.'

12.2.3 The duty of a hospital to provide care is a non-delegable duty

Robertson v Nottingham HA (1997) CA

The plaintiff sued for negligence after she had been born with cerebral palsy. She alleged that the defendants had negligently interpreted cardiotocographic (CTG) recordings and had failed to act promptly enough once the trace became abnormal.

Held: the delay caused by the doctor's incompetence was no more than two hours. There was evidence that the catastrophic event that caused the plaintiff's condition had occurred before the mother had been admitted to hospital. Thus, the culpable delay had not contributed to the injury and there was no liability.

The Court of Appeal held that there had been 'significant breakdowns in the defendants' systems of communication which represented breaches of proper practice'. Brooke LJ stated:

Although it is customary to say that a health authority is vicariously liable for a breach of duty if its responsible servants or agents fail to set up a safe system of operation in relation to what are essentially management as opposed to clinical matters, this formulation may tend to cloud the fact that in any event it has a non-delegable duty to establish a proper system of care just as much as it has a duty to engage competent staff and a duty to provide proper and safe equipment and safe premises.

Note

Direct liability has been found for unsafe drug procedures (*Collins v Hertfordshire County Council* (1947)); negligently drafted consent forms (*Worster v City and Hackney HA* (1987)); failure to provide sufficiently skilled staff (*Wilsher v Essex AHA* (1986) CA—judgment reversed by House of Lords on causation); inadequate supervision of staff (*Jones v Manchester Corporation* (1952)); inadequate system for checking equipment (*Denton v South West Thames RHA* (1981)); and a failure to communicate up to date information to members of staff (*Blyth v Bloomsbury HA* (1993)).

12.3 Liability of the ambulance service

12.3.1 Once it has agreed to answer a 999 call, the ambulance service owes a duty of care to the subject of the call

Kent v Griffiths (2000) CA

P suffered a respiratory arrest after an ambulance failed to arrive in a reasonable time. No satisfactory reason was given for the delay.

Held: the ambulance service could owe a duty of care to a member of the public on whose behalf a 999 call had been made if, for no good reason, an ambulance it despatched failed to arrive within a reasonable time.

Lord Woolf MR stated:

> Here what was being provided was a health service… Why should the position of the ambulance staff be different from that of doctors or nurses? In addition, the arguments based on public policy are much weaker in the case of the ambulance service than they are in the case of the police or fire service. The police and fire services' primary obligation is to the public at large… But in the case of the ambulance service in this particular case, the only member of the public who could be adversely affected was the claimant… Having decided to provide an ambulance, an explanation is required to justify a failure to attend within reasonable time.

Note

Under similar circumstances, it is unlikely that the police or fire service would be held to owe a duty of care to the subject of a 999 call. See *Capital and Counties plc v Hampshire CC* (1996) CA.

Think point

What are the possible justifications for Lord Woolf MR's argument that the ambulance service is more like a hospital than the police or fire service?

12.4 Standard of care

12.4.1 A doctor will not be liable in negligence if he acts in accordance with a practice accepted as proper by a responsible body of doctors

Bolam v Friern Hospital Management Committee (1957)

The plaintiff, who suffered from depression, was treated with electro-convulsive therapy (ECT). This treatment induces convulsions (a fit) by passing an electrical current through the brain. The defendants failed to warn the plaintiff of the slight risk of bone fracture. In accordance with the hospital's normal practice, the doctors did not administer a muscle relaxant or apply manual restraint. The plaintiff suffered bilateral hip fractures. The plaintiff alleged negligence in:

(a) failing to use a muscle relaxant;
(b) failing to provide sufficient manual restraint; and
(c) failing to warn of the risks associated with the treatment.

Expert opinion was divided on the issues.

Held: the defendants were not liable for negligence.

In directing the jury, McNair J stated:

> 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.

Note

The *Bolam* test has been accepted and applied in many cases including those before the House of Lords. Thus, it has been held

to apply to diagnosis (*Maynard v West Midlands RHA* (1984) HL); treatment (*Whitehouse v Jordan* (1981) HL); and disclosure of information (*Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* (1985) HL). It has also been applied to the issue of causation (see later, *Bolitho v City and Hackney HA* (1997) HL).

12.4.2 The court reserves the right to decide that a responsible body of physicians would not accept the practice as proper

Hills v Potter (1984)

For the facts and decision, see 2.2.4.

Hirts J stated:

> I do not accept the argument that by adopting the *Bolam* principle the court in effect abdicates its power of decision to the doctors. In every case the court must be satisfied that the standard contended for on their behalf accords with that upheld by a substantial body of medical opinion, and that this body of medical opinion is both respectable and responsible, and experienced in this particular field of medicine.

Hucks v Cole (1994) CA (decided in 1968)

The plaintiff was a pregnant woman who had developed a septic spot on one of her fingers. She subsequently developed a similar spot on one of her toes. The defendant general practitioner sent a swab to the laboratory to determine what the infection was. He started the plaintiff on a course of tetracycline (an antibiotic). The laboratory report suggested that penicillin was the appropriate antibiotic. The defendant did not change the plaintiff's treatment. She later developed fulminating septicaemia. The defendant's actions were consistent with the practice of other 'responsible' doctors. The trial judge found the defendant negligent for failing to prescribe penicillin once it was clear that the lesions had not fully healed following the course of tetracycline. The defendant appealed.

Held: appeal dismissed. The defendant had been negligent.

Sachs LJ stated:

> When the evidence shows that a *lacuna* in professional practice exists by which risks of grave danger are knowingly taken, then, however small the risks, the courts must anxiously examine that *lacuna*—particularly if the risks can be easily and inexpensively avoided. If the court finds, on an analysis of the reasons given for not taking those precautions that, in the light of current professional knowledge, there is no proper basis for the *lacuna,* and that it is definitely not reasonable that those risks should have been taken, its function is to state that fact and where necessary to state that it constitutes negligence.

Bolitho v City and Hackney HA (1997)

For the facts and decision, see 12.5.3.

Lord Browne-Wlkinson stated:

> [I]n my view, 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… The use of these adjectives [in previous cases]—responsible, reasonable and respectable—all show that 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…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.

However, he later added the caveat:

> I emphasise 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. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence… 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.

See, also, for example, *Newell and Newell v Goldenberg* (1995); *Smith v Tunbridge Wells HA* (1994).

> Note
>
> The reluctance of the courts to rule a medical opinion as unreasonable is shown by the Court of Appeal's judgment in *Winiewski v Central Manchester HA* (1998). The Court of Appeal overruled the High Court's decision that the expert witness' evidence could not be logically supported as representing a reasonable body of medical opinion. However, the defendant's appeal was still dismissed on other grounds.

12.4.3 The court will not choose between the different opinions of responsible bodies of physicians

Maynard v W Midlands RHA (1985) HL

The plaintiff underwent a diagnostic mediastinoscopy to determine whether tuberculosis or Hodgkin's disease caused her enlarged lymph

nodes. During the operation, her left recurrent laryngeal nerve was damaged resulting in paralysis of her left vocal cord. The plaintiff sued the Health Authority alleging that the diagnosis of tuberculosis was certain enough to make the doctors negligent in requiring the further diagnostic procedure. The expert witnesses were divided as to whether the decision to operate was appropriate. At first instance the defendants were held to be negligent. The Court of Appeal overturned the decision and the plaintiff appealed.

Held: appeal denied. The defendants had not been negligent.

Lord Scarman stated:

> It is not enough to show that there is a body of competent professional opinion which considers theirs as a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances… I do not think that the words of Lord President (Clyde) in *Hunter v Hanley* 1955 SLT 213 at page 217 can be bettered:
>
> > 'In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man is not negligent merely because his conclusion differs from that of other medical men… 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.'

12.4.4 The body of responsible medical opinion does not have to be substantial

DeFreitas v O'Brien (1995) CA

The plaintiff suffered from chronic back and neck pain. An initial operation was unsuccessful and the plaintiff developed further pain and a swelling in the small of her back. Despite a myelogram indicating that there was no evidence of nerve root compression, she underwent a second operation during which the surgeon noted that there was severe compression of the L4-S1 nerve roots. After the operation she developed further pain in her back and legs that were relieved by epidural injections. The back wound became infected and her condition deteriorated Eventually she underwent an operation to close a fistula that had been leaking cerebrospinal fluid (CSF) (the fluid that bathes the brain and spinal cord). She was left with an indwelling shunt and chronic arachnoiditis (inflammation of one of the layers of tissue that contains the CSF). The plaintiff made a number of claims of negligence, which could be summed up as 'overall Mr O'Brien's decisions were not those which a responsible body of medical opinion could have reached'. The evidence was that within the 1,000 and more doctors that comprised

the specialities of orthopaedics and neurosurgery, there were only 11 who would be called 'spinal surgeons'. It was only this small sub-specialised group who would have countenanced surgery in this case. At first instance, the judge found the defendant not liable. The plaintiff appealed.

Held: appeal dismissed.

Otton LJ stated:

> I do not consider the learned judge fell into an error in not considering whether the body of spinal surgeons had to be substantial. It was sufficient if he was satisfied that there was a responsible body.

Note

This decision has been criticised for licensing risk taking. In one sense, the Court of Appeal was correct in noting that the appropriate test is 'responsible' but the issue of the number of doctors required to constitute a body of opinion is important. As Khan and Robson (1995) have noted: 'Numbers must play a part in determining whether the practice is accepted and therefore responsible.'

12.4.5 The standard of care depends on the post occupied by the doctor and not on the level of training the doctor has received

Wilsher v Essex AHA (1988) HL

For the facts and decision, see 12.5.4.

In the Court of Appeal hearing of the case, the majority held that the standard of care required of a doctor is assessed in relation to the post he holds rather than the training he has received.

In rejecting the individualised standard, Mustill LJ stated:

> …this notion of a duty tailored to the actor, rather than to the act which he elects to perform, has no place in the law of tort.

Think point

What are the implications for a junior doctor who fills in for a more senior doctor?

12.4.6 The standard of care is to be judged against the knowledge available at the time of the incident and not at the time of the trial

Roe v Ministry of Health (1954) CA

The two plaintiffs were each given a spinal anaesthetic. The anaesthetic administered had been stored in phenol that had seeped through microscopic cracks in the glass ampoules and contaminated the anaesthetic. Both plaintiffs were left permanently paralysed. The risk that this might occur was first drawn attention to in a book published in 1951, four years after the plaintiffs had received the fateful anaesthetics.

Held: appeal denied. There was no liability. The standard of care was to be judged against the knowledge that prevailed at the time of the incident.

Lord Denning stated:

> It is so easy to be wise after the event…we must not look at the 1947 accident with 1954 spectacles.

12.4.7 The standard of current knowledge will not be based on the publication of isolated articles in medical journals

Crawford v Board of Governors of Charing Cross Hospital (1953) CA

The plaintiff underwent a bladder operation during which his left arm was positioned in such a way that it damaged the nerves resulting in permanent weakness. The position was a standard one, but six months prior to the operation, an article had appeared in the *Lancet* warning of the potential dangers of the position. The anaesthetist looking after the patient had not read the article. At first instance the judge held that the anaesthetist was negligent in failing to keep up to date. The defendants appealed.

Held: appeal allowed. There was no evidence of negligence.

Lord Denning stated:

> …it would, I think, be putting too high a burden on a medical man to say that he has to read every article appearing in the current medical press; and it would be quite wrong to suggest that a medical man is negligent because he does not at once put into operation the suggestions which some contributor or other might make in a medical journal. The time may come in a particular case when a new recommendation may be so well proved and so well known, and so well accepted that it should be adopted, but that was not so in this case.

12.4.8 Departure from accepted practice does not automatically constitute negligence

Hunter v Hanley (1955)

The plaintiff suffered from chronic bronchitis, for which the defendant was treating her by a course of intra-muscular injections of an antibiotic. On the final injection, the needle broke and the tip remained embedded in the plaintiff's buttock. The plaintiff alleged the defendant was negligent in the choice of needle he used. At first instance, the defendant was found not liable. The plaintiff appealed.

Held: the judge's direction to the jury was inaccurate. A new trial was ordered.

Lord President Clyde stated:

> …a deviation [from ordinary professional practice] is not necessarily evidence of negligence. Indeed it would be disastrous if this were so, for all inducement to progress in medical science would then be destroyed. Even a substantial deviation from normal practice may be warranted by the particular circumstances. 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 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.

12.4.9 The standard of care required may be lower in an emergency

Wilsher v Essex AHA (1988) HL

For the facts and decision, see 12.5.4.

Mustill LJ stated:

> An emergency may overburden the available resources, and if an individual is forced by circumstances to do many things at once, the fact that he does one of them incorrectly should not lightly be taken as negligence.

Note

In *Powell v Boldaz* (1997), Smith LJ stated: '…a doctor who goes to the assistance of a stranger injured in an accident…does not as a rule undertake the doctor-patient relationship so as to make him liable for lack of care, but only a duty not to make the condition of the victim worse.' This mirrors his statement in *Capital and Counties plc v Hants CC* (1997): '…a doctor who happened to witness a road accident will

very likely go to the assistance of anyone injured, but he is not under any legal obligation to do so (save in certain limited circumstances) and the relationship of the doctor and patient does not arise. If he volunteers his assistance, his only duty as a matter of law is not to make the victim's condition worse.' This suggested standard is analogous to that expected of public bodies exercising a statutory power (see *Stovin v Wise* (1996)). However, Smith LJ's comments are *obiter* and in these circumstances, the doctor is not acting as an agent for a public body but as a private individual with the special skills of a doctor. Once he has stopped to offer assistance the doctor has voluntarily assumed responsibility and thus a duty of care should exist. It is suggested that the *Bolam* standard - which allows the difficulty of the circumstances to be taken into account—would apply.

12.5 Breach of duty and causation

12.5.1 The burden of proof lies with the claimant to prove that, on the balance of probabilities, the defendant was negligent

Ashcroft v Mersey RHA (1983)

The plaintiff underwent an operation on her left ear to remove some granulation tissue on her eardrum. During the operation the surgeon damaged the plaintiff's facial nerve resulting in a partial paralysis of the left side of her face. The plaintiff's expert witness testified that the injury could only have occurred through negligence. The defendant, supported by the evidence of an eminent ear surgeon, denied the claim.

Held: the plaintiff had failed to establish, on the balance of probabilities, that the surgeon had fallen below the requisite standard of care.

Note

In *Bolitho,* Lord Browne-Wilkinson stated: 'Where, as in the present case, a breach of a duty of care is proved or admitted, the burden still lies on the plaintiff to prove that such breach caused the injury suffered.'

12.5.2 The claimant must prove that the damage would not have occurred but for the negligence of the defendants

Barnett v Chelsea and Kensington Hospital Management Committee (1969)

The plaintiff's husband, along with two other night watchmen, went to the accident and emergency department of the defendant's hospital. They complained to the duty nurse that they had been vomiting continuously since drinking some tea. The nurse informed the on duty doctor who replied that they should go home to bed and call in their own doctors. The plaintiff's husband died a few hours later from arsenic poisoning. The plaintiff sued.

Held: the doctor had breached his duty of care, but the plaintiff's husband would have died whatever the doctor had done. The defendants' lack of care had not caused Mr Barnett's death.

12.5.3 Where the doctor has breached his duty of care by an omission then the *Bolam* test may be applied in determining whether the omission has caused the claimant's damage

Bolitho v City and Hackney HA (1997) HL

The plaintiff was a two year old boy who was admitted to hospital suffering from the respiratory infection, croup. His condition fluctuated and the doctors were asked to see him but failed to do so. The plaintiff deteriorated again and while the nurse was trying to 'bleep' one of the doctors the nurse with the plaintiff set off the emergency buzzer. The plaintiff suffered a cardiac arrest and was left with severe brain damage. The plaintiff's experts claimed that the disastrous outcome could have been avoided if the plaintiff had been intubated. The defendants acknowledged that the doctor had breached her duty of care by failing to attend the plaintiff when asked to by the nurse, but claimed that she would not have intubated the plaintiff even if she had attended. The defendant's experts testified that, on the evidence, intubating the plaintiff would not have been the desirable or necessary course of action. At first instance, faced with a division of expert opinion, the judge held that negligence had not been proved. The plaintiff appealed, first to the Court of Appeal and then to the House of Lords.

Held: appeal denied. Causation had not been proved.

Lord Browne-Wilkinson stated:

> There were…two questions for the judge to decide on causation: (1) what would Dr Horn have done, or authorised to be done, if she had attended Patrick?;

and (2) if she would not have intubated, would that have been negligent? The *Bolam* test has no relevance to the first of those questions but is central to the second.

12.5.4 Where the defendant's negligence is just one of many possible causes of the claimant's damage, it is for the claimant to prove—on the balance of probabilities—that 'but for' the defendant's negligence, the damage would not have occurred

Wilsher v Essex AHA (1988) HL

The plaintiff was a baby born three months prematurely. He had breathing problems and needed supplemental oxygen. In order to monitor treatment, a catheter was inserted. Unfortunately, it was inserted into a vein rather than an artery, which meant that the oxygen levels measured, appeared to be lower than they actually were. The line was removed and replaced, but was again misplaced into a vein. X-rays were taken to inspect the position of the catheter but the misplacement was not picked up. Because the oxygen readings appeared low, increased amounts of oxygen were given. The plaintiff developed retrolental fibroplasia and was left nearly blind. He sued the Health Authority, alleging that this resulted from the excess oxygen he was given.

Held: there were five other possible causes of the retrolental fibroplasia and the plaintiff had failed to establish causation.

Note

In *McGhee v National Coal Board* (1973) HL, the plaintiff alleged that the dermatitis he developed was caused by the defendants' failure to provide washing facilities in the brick kilns where he worked. He was unable to prove that he would not have developed the dermatitis even if the facilities had been available. However, there was evidence to suggest that the lack of facilities materially increased the risk of the dermatitis, thus there was a material contribution to the injury and the defendants were liable. The case was distinguished in *Wilsher* because in *McGhee* there was only one possible 'agent'—the brick dust while in *Wilsher* there were five.

Lord Bridge commented:

> *McGhee*…laid down no new principle of law… Adopting a robust and pragmatic approach to the undisputed primary facts of the case, the majority concluded that it was a legitimate inference of fact that the defenders' negligence had materially contributed to the pursuer's injury.

Think point

Was the House of Lords justified in distinguishing *McGhee*?

12.5.5 Where the defendant's negligence has deprived the claimant of the possibility of successful treatment, the claimant must show that, on a balance of probabilities, the delay or failure to treat was at least a material contributory cause of the damage

Hotson v East Berkshire HA (1987) HL

A schoolboy fell out of a tree and injured his hip. The defendant failed to X-ray the hip and the true extent of his injury went undiscovered for several days. He was left with a permanent disability. The medical evidence was that in 75% of cases the injury was such that even if the injury had been diagnosed immediately he would still have been left with the disability. The plaintiff sued, not on the basis of the disability but for the loss of the 25% chance of recovery. The trial judge awarded damages at 25% of the amount that would have been awarded for his disability. This was affirmed by the Court of Appeal.

Held: appeal allowed. If the plaintiff could show on the balance of probabilities that he would have recovered if given proper treatment then he was entitled to full damages. If he could not, then he was not entitled to recover at all.

Note

The House of Lords left it open whether it would ever be possible to claim for lost damages. Lord Bridge's speech suggests that if the probability of recovery had been 51% then he might have been entitled to damages since, on the balance of probabilities, treatment would have been successful. This argument—that a plaintiff was entitled to damages if the chance of recovery was greater than 50%—had been previously applied in *Kenyon v Bell* (1953). The plaintiff in that case was a girl who lost the sight in one eye following negligent treatment. However, the court held there was no liability because even if the medical treatment had been of the requisite standard she would still have had a less than 50% chance of retaining the sight in her eye. In *Allied Maples Group Ltd v Simmons* (1995), the Court of Appeal held that if the lost chance represented a real and substantial possibility rather than just a speculative chance, then recovery would be allowed.

12.5.6 Where damage has occurred and the negligent event cannot be clearly identified the claimant may raise *res ipsa loquitur* —the thing (damage) speaks for itself. Under *res ipsa loquitur,* it is for the defendants to rebut the evidential presumption of negligence that the principle establishes

Cassidy v Ministry of Health (1951) CA

For the facts and decision, see 12.2.2.

Lord Denning stated:

> If the plaintiff had to prove that some particular doctor or nurse was negligent, he would not be able to do it. But he was not put to that impossible task. He says: 'I went into the hospital to be cured of two stiff fingers. I have come out with four stiff fingers, and my hand is useless. That should not have happened if due care had been used. Explain it if you can.'

Note

The courts are reluctant to apply the doctrine in medical negligence cases, especially where the procedure in question carried a high risk: see *Whitehouse v Jordan* (1980), in which Lord Denning MR stated: '…the first sentence suggests that, because the baby suffered damage, therefore Mr Jordan was at fault. In other words *res ipsa loquitur*. That would be an error. In a high risk case, damage during birth is quite possible, even though all care is used. No inference of negligence should be drawn from it.'

The requirements that must be satisfied before the principle can apply were laid down in *Scott v London and St Katherine Docks Co* (1865):

(1) whatever causes the damage must be under the management of the defendant or his servants;
(2) if proper care had been used the accident is such that it would not normally happen;
(3) the defendants are unable to provide an explanation for the accident.

Thus, all the doctrine does is to satisfy the claimant's burden of proof, which is rebuttable if the defendants can provide a reasonable explanation. It does not shift the burden of proof to the defendants.

12.5.7 For *res ipsa loquitur* to be rebutted the defendant's explanation must be reasonable

Saunders v Leeds Western HA (1985)

The plaintiff, a 4 year old girl, suffered a heart attack during an operation to correct a congenitally dislocated hip. She was left with permanent brain damage. She claimed that the heart of a fit child did not arrest under anaesthesia without negligence—*res ipsa loquitur*. The defendants' explanation was that a paradoxical air embolism had travelled from the operation site to the patient's heart where it had blocked a coronary artery.

Held: liability was established. The defendants' explanation was rejected as they would have been forewarned of any problems if they had employed a proper system of monitoring.

See, also, *Glass v Cambridge HA* (1995).

12.5.8 If the defendant's practice deviates from the accepted standard, he must be able to justify his actions

Clark v MacLennan (1983)

The plaintiff developed stress incontinence after giving birth. To treat the condition an anterior colporrhaphy was performed four weeks after the birth. The operation was a failure and two subsequent operations also failed. The plaintiff alleged negligence because the standard practice was to wait three months post-delivery, in order to avoid the very complications the plaintiff suffered.

Held: the defendants had not justified their departure from standard practice and were thus liable for negligence.

Pain J stated:

> Where…there is but one orthodox course of treatment and the doctor chooses to depart from that…it is not enough for him to say as to his decision simply that it was based on his clinical judgment. One has to inquire whether he took all the proper factors into account which he knew or should have known, and whether his departure from the orthodox course can be justified on the basis of these factors.

Note

In *Wilsher v Essex AHA* (1986) CA, Mustill LJ argued that this case could only be properly understood as creating a presumption of negligence that the defendant must rebut by justifying his actions. As with *res ipsa loquitur,* the burden of proof is not shifted to the defendant.

12.5.9 The chain of causation can be broken by an intervening act *(novus actus interveniens)* which relieves the defendant of liability

Rance v Mid-Downs HA (1991)

The plaintiff alleged that the defendants negligently failed to diagnose that her fetus had spina bifida leaving her with a disabled child. At the time she was twenty six weeks pregnant and abortion law—as drafted at the time—would have made it unlawful to terminate the pregnancy.

Held: she would not have been able to lawfully terminate her pregnancy anyway and thus, the provisions of the law broke the chain of causation.

12.5.10 For the claimant's own act to constitute a *novus actus*, it must have been unreasonable

Emeh v Kensington and Chelsea and Westminster AHA (1985) CA

The plaintiff alleged that a sterilisation performed at the same time as an abortion had been carried out negligently. The plaintiff did not discover the subsequent pregnancy until she was 20 weeks into her gestation. She decided to keep the child which was born with congenital abnormalities. She claimed damages for the pregnancy, birth and costs of raising a handicapped child. At first instance, the judge held that her decision not to have a termination was a *novus actus interveniens*.

Held: appeal allowed. Damages would be allowed for the full extent of the consequences of the defendants' negligence.

Slade LJ stated:

> Save in the most exceptional circumstances, I cannot think it right that the court should ever declare it unreasonable for a woman to decline to have an abortion.

Note

The House of Lords have held that damages are not available for the costs of raising a normal child following a 'wrongful birth' (see 8.7.2), but they have been allowed for the cost incurred where the child is disabled (see 8.7.3).

12.5.11 The damage must not be too remote—the type of harm must be reasonably foreseeable

Hepworth v Kerr (1995)

The defendant anaesthetised the plaintiff using the experimental anaesthetic technique of induced hypotension. The plaintiff subsequently suffered a

spinal stroke (damage to the spinal cord caused by a reduced blood supply). It was known that there was a risk of cerebral stroke but there was no knowledge of the risk of spinal stroke.

Held: the defendant was liable. Although the spinal stroke was not foreseeable, injury from under-perfusion of a major organ was foreseeable. The damage was of this type and thus it was not too remote.

12.6 Damages

There are no special rules applied to damages awarded in cases of medical negligence. The general aim is to return the claimant, as far as possible, to their position before the tort occurred. The damages are calculated to compensate for their losses and generally not to punish the defendant. There are three main components to damages awards (Brazier and Murphy (1999)):

(1) pecuniary loss—for example, loss of earnings;
(2) cost of care—medical expenses, etc.
(3) non-pecuniary loss—pain, suffering, loss of amenity.

Heil v Rankin (2000) CA

In a joint hearing of several appeals the Court of Appeal considered the issue of the quantum of damages for pain, suffering and loss of amenity in light of the Law Commission's Report No 257 (1999). The defendants argued that it was inappropriate for the judiciary to alter the levels of damages as this should properly be done by Parliament.

Held: it was part of the Court of Appeal's duty to consider the level of damages and it could not wait for Parliament to intervene. It was inappropriate to increase the damages to the degree recommended by the Law Commission. The Court of Appeal set guidelines on the level of damages for pain, suffering and loss of amenity in personal injury and clinical negligence claims worth above £10,000. The awards would be graduated, the rate of increase being proportionate to the size of the award, up to a maximum increase of one-third on awards at the highest level. Damages of £150,000 were to be increased by 33%; those of £110,000 by 25%; those of £80,000 by 20%; and awards of £40,000 by 10%. Application for leave to appeal to the House of Lords pending.

12.7 Defences

The defences available include *volenti non fit injuria*, contributory negligence, and *ex turpi causa non oritur* action. *Volenti* arises when the claimant agrees to run the risk of the defendant's tortious act. There have been no medical cases and it is difficult to think of this defence ever being applicable in this field. *Ex turpi* is the rule that the courts will not give assistance to a claimant whose injury arose because they were engaged in criminal activities. The most likely defence to arise is contributory negligence.

12.7.1 The liability of the defendant will be reduced if the claimant has contributed to the extent of the damage—contributory negligence

Crossmann v Stewart (1977) Supreme Court of British Columbia

The plaintiff suffered from a skin disorder and was prescribed treatment (chloroquine) for this by the defendant. She was employed as a medical receptionist and when her supply ran out she obtained the drug without prescription from the salesman, who supplied her employer with the drugs he needed for his practice. The defendant was unaware of this. The defendant became aware of evidence that suggested that long term use of the drug might cause blindness. He contacted the plaintiff and referred her to an eye specialist. The eye specialist diagnosed 'bilateral superficial keratopathy…which suggests a sequelae of chloroquine therapy'. The plaintiff was informed that the specialist's report was negative and she continued to take the drug without the defendant's knowledge. She subsequently consulted him and he continued her on the treatment for a further six months. Over the next six years, the plaintiff's sight progressively deteriorated. She sued the defendant.

Held: the defendant was liable for negligence for failing to properly consider the eye specialist's report. The plaintiff was guilty of contributory negligence in obtaining the prescription drugs without her doctor's knowledge. The plaintiff was two-thirds responsible for her damage and thus could only recover one-third from the plaintiff.

Section 1 of the Law Reform (Contributory Negligence) Act 1945

> Where any person suffers damage as the result partly of his own fault and partly of the fault of any other person or persons, a claim in respect of that damage shall not be defeated by reason of the fault of the person suffering the damage, but the damages recoverable in respect thereof shall be reduced to such extent as the court thinks just and equitable having regard to the claimant's share in the responsibility for the damage…

12.7.2 A claimant will not be contributorily negligent if his/her acts or omissions are reasonable

Bernier v Sisters of Service (1948) Alberta Supreme Court

The plaintiff was admitted for an appendicectomy. She had previously suffered frostbite of her feet, which she did not volunteer. She was given a spinal anaesthetic (which would reduce or block sensation from her feet) for the appendicectomy. Nurses placed two hot water bottles inside the foot of her bed and then left the ward. Over the next 20 minutes, the plaintiff began to moan. The bottles were removed some 10 minutes later, but the plaintiff had suffered third degree burns to both heels. She sued the hospital, which alleged contributory negligence.

Held: the hospital staff had been negligent in failing to test the hot water bottles with a thermometer, placing them directly against her feet and not having a nurse in attendance. The plaintiff was not guilty of contributory negligence. She had no reason to think that the frostbite was relevant. The allegation that she had failed to communicate the pain was irrelevant because the damage was done before the sensation returned to her feet.

Note

This is simply applying the 'reasonable person' standard to the claimant as well as the defendant. It would be unjust to expect the claimant to achieve a higher standard of care than the defendant.

12.8 Time limitations on actions for personal injury

12.8.1 The limitation period for personal injury actions is three years

Section 11 of the Limitation Act 1980

(1) This section applies to any action for damages for negligence, nuisance or breach of duty…in respect of personal injuries…
(3) An action to which this section applies shall not be brought after the expiration of the period applicable in accordance with sub-s (4) or (5) below.
(4) Except where sub-s (5) below applies, the period applicable is three years from—

(a) the date on which the cause of action accrued; or
(b) the date of knowledge (if later) of the person injured.

(5) If the injured person dies before the expiration of the period mentioned in sub-s (4) above, the period applicable as respects the cause of action surviving for the

benefit of his estate by virtue of s 1 of the Law Reform (Miscellaneous Provisions) Act 1934 shall be three years from—

(a) the date of death; or
(b) the date of the personal representative's knowledge; whichever is the later.

12.8.2 Knowledge of the cause of the damage includes both actual and constructive knowledge

Section 14 of the Limitation Act 1980

(1) Subject to sub-s 1A below, in ss 11 and 12 of this Act, references to a person's date of knowledge are references to the date on which he first had knowledge of the following facts—

(a) that the injury in question was significant; and
(b) that the injury was attributable in whole or in part to the act or omission which is alleged to constitute negligence, nuisance or breach of duty; and
(c) the identity of the defendant; and
(d) if it is alleged that the act or omission was that of a person other than the defendant, the identity of that person and the additional facts supporting the bringing of an action against the defendant.

(3) For the purposes of this section, a person's knowledge includes knowledge which he might reasonably have been expected to acquire—

(a) from facts observable or ascertainable by him; or
(b) from facts ascertainable by him with the help of medical or other appropriate expert advice which it is reasonable for him to seek; but a person shall not be fixed under this sub-section with knowledge of a fact ascertainable only with the help of expert advice so long as he has taken all reasonable steps to obtain (and, where appropriate, act on) that advice.

Davis v City and Hackney HA (1989)

The plaintiff was born with severe physical disabilities. When he was 17 years old he questioned his mother about the cause of his disability. She suggested that it might have been a mishandled delivery. She was reluctant for him to make any claim for damages. After he had left home he met a law student—when he was 22—who thought that he might have a possible claim. He then consulted a solicitor. Just over one year later, they received a medical report. Five months later they issued a writ, which alleged that his disabilities were due to an injection of Ovametrin administered to his mother. The defendants pleaded that the case was time barred.

Held: the claim was not statute barred. The plaintiff's knowledge (s 11(4)(b) of the Limitation Act 1980) arose at the time that the contents of the medical report were communicated to him. The plaintiff's disabilities meant that he had not been unreasonable in failing to seek legal advice any earlier. He could not be fixed with constructive knowledge at any earlier date under s 14(3).

Jowitt J stated:

> I turn now to s 14(3). The test is an objective one…but it is an objective test applied to the kind of plaintiff I am here dealing with, with his disability, and looking at his age and his circumstances and the difficulties he has faced.

12.8.3 The three years time limit does not start to run if the claimant is not legally competent

Limitation Act 1980

28(1) Subject to the following provisions of this section, if on the date when any right of action accrued for which a period of limitation is prescribed by this Act, the person to whom it accrued was under a disability, the action may be brought at any time before the expiration of six years from the date when he ceased to be under a disability or died (whichever first occurred) notwithstanding that the period of limitation has expired.

(6) If the action is one to which ss 11 or 12(2) of this Act applies, sub-s (1) above shall have effect as if for the words 'six years' there were substituted the words 'three years'.

38(2) For the purposes of this Act, a person shall be treated as under a disability while he is an infant, or of unsound mind.

Headford v Bristol and District HA (1995) CA

The plaintiff brought a claim in negligence against the defendants for personal injury resulting from an operation performed 28 years previously that had left the plaintiff severely mentally disabled. At first instance, the judge held that the delay, caused by the plaintiff's carers, was unreasonable, prejudicial to the defendants and an abuse of process. The plaintiff appealed.

Held: appeal allowed. Section 28 of the Limitation Act 1980 makes no reference to 'prejudice' and contained no provision to restrict the time limit for a plaintiff who remained disabled. Since the plaintiff remained disabled and s 28 conferred a right in general to bring proceedings in negligence at any time during the period of continuing disability, the plaintiff was not time barred.

12.8.4 The court has the discretion to allow time barred claims if it is equitable

Section 33 of the Limitation Act 1980

(1) If it appears to the court that it would be equitable to allow an action to proceed having regard to the degree to which—

(a) the provisions of ss 11, 11A or 12 of this Act prejudice the plaintiff or any person whom he represents; and
(b) any decision of the court under this sub-section would prejudice the defendant or any person whom he represents; the court may direct that those provisions shall not apply to the action, or shall not apply to any specified cause of action to which the action relates.

(3) In acting under this section, the court shall have regard to all the circumstances of the case and in particular to—

(a) the length of, and the reasons for, the delay on the part of the plaintiff;
(b) the extent to which…the evidence…is likely to be less cogent than if the action had been brought within the time allowed…;
(c) the conduct of the defendant after the cause of action arose…;
(d) the duration of any disability of the plaintiff arising after the date of the accrual of the cause of action;
(e) the extent to which the plaintiff acted promptly and reasonably once he knew whether or not the act or omission of the defendant, to which the injury was attributable, might be capable at that time of giving rise to an action for damages;
(f) the steps, if any, taken by the plaintiff to obtain medical, legal or other expert advice and the nature of any such advice he may have received.

Mold v Hayton and Newson (2000) CA

The claimant alleged that had she been examined vaginally in late 1979 or early 1980, the cervical cancer from which she suffered would have been detected earlier than it was. This would have meant that she could have had lower doses of radiotherapy and would have avoided the side effects she suffered. Her claim was not made until 1998. At first instance, the judge held that she had knowledge of the facts from September 1980, when she was diagnosed with the cervical cancer. However, he exercised his discretion under s 33 of the Limitation Act 1980 and extended the time limit to allow her to bring the claim. The defendants appealed. The claimant cross-appealed against the judge's finding of the date of her knowledge.

Held: (1) dismissing the cross-appeal, the damage was the failure to diagnose the cancer and not the development of the side effects. Thus, the judge was correct in construing knowledge from the date of the actual

diagnosis; (2) appeal allowed. The delay of 18 years was a huge delay and as such the judge was under a duty to give reasons for allowing the extension. He had failed to do this. Also, the claimant had been unable to cite any precedents for such a long extension and the defendants were not responsible for the delay in bringing the proceedings. It was not reasonable for them to be sued so many years after the events.

13 Liability for Defective Products

13.1 Common law liability

13.1.1 The 'manufacturer' of a product owes a duty of care not to injure the 'consumer'

Donoghue v Stevenson (1932) HL

The plaintiff went to a café with a friend, who purchased a bottle of ginger beer (the bottle was opaque which made it impossible to inspect the contents). The plaintiff drank some of the ginger beer and then her friend poured the remainder of the bottle into the glass. It was alleged that the remains of a decomposed snail was poured out with the ginger beer. The plaintiff claimed that she subsequently became ill with gastro-enteritis and sued the manufacturers of the ginger beer for negligence. The manufacturers claimed that there could be no liability since there was no contract with the plaintiff.

Held: liability could exist. A manufacturer owed a duty of care to the consumer irrespective of any contract.

Lord Atkin stated:

> …a manufacturer of products, which he sells in such a form as to show that he intends them to reach the ultimate consumer in the form in which they left him with no reasonable possibility of intermediate examination and with the knowledge that the absence of reasonable care in the preparation or putting up of the products will result in an injury to the consumer's life or property, owes a duty to the consumer to take reasonable care.

Note

Liability in ordinary negligence requires that the plaintiff show that the manufacturer had failed to take reasonable care and that the defect produced by the manufacturer's carelessness caused the damage. It may be very difficult to show that the medical product (for example, a drug), rather than the patient's pre-existing illness, caused the damage. Thus, in *Loveday v Renton* (1990), the plaintiff was unable to show that the pertussis

(whooping cough) vaccine was even capable of causing the damage suffered (compensation was, however, subsequently paid under the Vaccine Damage Payments Act 1979). For the finer points of liability for defective products in common law, see any casebook or textbook on tort law.

13.2 Statutory liability

For damage caused by vaccines, no fault compensation has been provided by the Vaccine Damage Payments Act 1979. The Act provides for a statutory sum (currently £100,000: the Vaccine Damage Payments Act 1979; Statutory Sum Order 2000) that may be awarded by the Secretary of State if he is satisfied 'that a person is, or was immediately before his death, severely disabled as a result of vaccination' (s 1(1)(a)). The Act only applies to the list of diseases detailed in s 2 and is limited in its effect to those who are severely disabled, which means 'if he suffers disablement to the extent of 80% or more'. Under s 3(5), the claimant must prove on the balance of probabilities that the vaccine caused the damage. Section 3(4) allows the right of appeal from the decision of the Secretary of State to an independent medical tribunal.

13.2.1 There is a strict (no fault) liability for defective products

Section 2 of the Consumer Protection Act 1987

(1) Subject to the following provisions of this part, where any damage is caused wholly or partly by a defect in a product, every person to whom sub-s (2) below applies shall be liable for the damage.
(2) This sub-section applies to—

(a) the producer of the product;
(b) any person who, by putting his name on the product or using a trademark or other distinguishing mark in relation to the product, has held himself out to be the producer of the product;
(c) any person who has imported the product into a Member State from a place outside the Member State in order, in the course of any business of his, to supply it to another.

Note

Section 2(2)(c) means that a supplier who imports the product from outside the European Community (EC) will be liable for a defective product even though they did not cause the defect. Suppliers acting

totally within the EC may be liable under s 2(3) if they fail, when asked, to identify any person who may be responsible for the product under s 2(2).

13.2.2 A 'product' may include natural substances such as blood or organs for transplantation

Section 1 of the Consumer Protection Act 1987

(2) In this part…'producer', in relation to a product, means—

(a) the person who manufactured it;
(b) in the case of a substance which has not been manufactured but has been won or abstracted, the person who won or abstracted it…

Note

The implication of this section is that a 'product' can be an abstracted 'substance'. It has been suggested by some academic commentators that this includes unmodified whole blood (see Mason and McCall Smith (1999)). It has now been accepted, in *A & Others v National Blood Authority* (2001), that blood is a 'product' within the meaning of the Consumer Protection Act 1987.

13.2.3 A 'defect' is present if the product is unsafe for its purpose

Section 3 of the Consumer Protection Act 1987

(1) Subject to the following provisions of this section, there is a defect in a product…if the safety of the product is not such as persons generally are entitled to expect…[including] safety in the context of risks of damage to property, as well as in the context of risks of death or personal injury.
(2) …all the circumstances shall be taken into account, including—

(a) the manner in which, and purposes for which, the product has been marketed, its get-up, the use of any mark in relation to the product and any instructions for, or warnings with respect to, doing or refraining from doing anything with or in relation to the product;
(b) what might reasonably be expected to be done with or in relation to the product; and
(c) the time when the product was supplied by its producer to another;

and nothing in this section shall require a defect to be inferred from the fact alone that the safety of a product which is supplied after that time is greater than the safety of the product in question.

Note

This section means that any risk inherent in the normal use of the product will not attract liability. Thus, an explanatory note from the Department of Trade and Industry (DTI) stated: 'A medicine used to treat a life threatening condition is likely to be much more powerful than a medicine used in the treatment of a less serious condition, and the safety that one is reasonably entitled to expect of such a medicine may therefore be correspondingly lower' (DTI, *Implementation of EC Directive on Product Liability: An Explanatory and Consultative Note*, 1985).

A & Others v National Blood Authority (2001)

The claimants had all been infected with Hepatitis C following transfusions with contaminated blood. The trial was to generically determine liability and quantum of damages under s 3 and s 4(1)(e) of the Consumer Protection Act 1987. The issues were considered in terms of Arts 6 and 7(e) of the Council Directive 85/874/EEC (The Product Liability Directive').

Held: The Directive was passed with the purpose of achieving a high level of consumer protection and the public had a legitimate expectation that blood would be safe (although not 100% safe). The defence under Art 7(e)—the state of knowledge defence—would only be effective once if the problem causing a defect was unknown. Once the problem had occurred and was known the defence would no longer be available. Thus, blood contaminated with the Hepatitis C virus was defective within the meaning of the Directive (and hence the Consumer Protection Act 1987).

13.2.4 A child injured pre-birth is protected by the Act

Section 6 of the Consumer Protection Act 1987

(3) Section 1 of the Congenital Disabilities (Civil Liability) Act 1976 shall have effect for the purposes of this part as if—

(a) a person were answerable to a child in respect of an occurrence caused wholly or partly by a defect in a product if he is or has been liable under s 2 above in respect of any occurrence on a parent of the child, or would be so liable if the occurrence caused a parent of the child to suffer damage; …

13.2.5 There are a number of statutory defences

Section 4 of the Consumer Protection Act 1987

(1) In any civil proceedings by virtue of this part against any person…it shall be a defence for him to show—

(a) that the defect is attributable to compliance with any requirement imposed by or under any enactment or with any Community obligation; or

(b) that the person proceeded against did not at the time supply the product to another; or

(c)(i) that the only supply of the product to another by the person proceeded against was otherwise than in the course of a business of that person's; and

(ii) that s 2(2) above does not apply to that person or applies to him by virtue of things done otherwise than with a view to profit; or

(d) that the defect did not exist in the product at the relevant time; or

(e) that the state of scientific and technical knowledge at the relevant time was not such that a producer of products of the same description as the product in question might be expected to have discovered the defect if it had existed in his products while they were under his control; or

(f) that the defect—

(i) constituted a defect in a product (the subsequent product) in which the product in question had been comprised; and

(ii) was wholly attributable to the design of the subsequent product or to compliance by the producer of the product in question with instructions given by the producer of the subsequent product.

Think point

Section 4(1)(e) is the 'development risk' defence; what are the justifications for and criticism of this defence?

13.2.6 A contractual remedy is available for patients who have purchased the product

Section 14 of the Sale of Goods Act 1979 (as amended)

14(2) Where the seller sells goods in the course of a business, there is an implied term that the goods supplied under the contract are of a satisfactory quality.

(2A) For the purposes of this Act, goods are of a satisfactory quality if they meet the standard that a reasonable person would regard as satisfactory, taking account of any description of the goods, the price (if relevant) and all the other relevant circumstances.

(2B) …the quality of goods includes their state and condition and the following (among others) are in appropriate cases, aspects of the quality of goods—

(a) fitness for all the purposes for which goods of the kind in question are commonly supplied;
(b) appearance and finish;
(c) freedom from minor defects;
(d) safety; and
(e) durability.

14 Liability in Criminal Law

14.1 Assault and battery

Theoretically, a doctor who operates on a patient without their consent could be liable for battery or for the more serious offences covered by ss 18 and 20 of the Offences Against The Person Act 1861. Liability would only arise where the doctor: failed to get any consent at all; operated on the wrong part of the body; or exceeded the scope of the consent without the justification of necessity. The same principles regarding the validity of a real consent—discussed in Chapter 2—relating to the tort of battery will apply to the criminal offence.

14.1.1 The doctrine of informed consent has no place in criminal law

R v Richardson (1998) CA

For the facts and decision, see 2.3.2.

Otton LJ stated:

> The general proposition which underlies this area of the law [of battery] is that the human body is inviolate, but there are circumstances which the law recognises where consent may operate to prevent conduct which would otherwise be classified as an assault from being so treated. Reasonable surgical interference is clearly such an exception.

Later he stated:

> It was suggested in argument that we might be assisted by the civil law of consent, where such expressions as 'real' or 'informed' consent prevail. In this regard, the criminal and civil law do not run along the same track. The concept of informed consent has no place in the criminal law. It would also be a mistake, in our view, to introduce the concept of a duty to communicate information to a patient about the risk of an activity before consent to an act can be treated as valid.

Note

Otton LJ's argument suggests that 'informed consent' is part of the civil law. This is misleading as the doctrine was rejected in *Sidaway* (see 2.4.1). In both criminal and civil law, consent can be vitiated by a mistake (whether fraudulently induced or not) only as to the identity of the actor or the nature or character of the act (see *R v Clarence* (1888); *Papadimitropolous v R* (1957)).

14.2 Negligent manslaughter

14.2.1 A doctor may be liable for manslaughter if a patient dies as a result of the doctor's negligence

R v Adomoko (1994) HL

The accused was an anaesthetist. During an operation, the tube carrying the oxygen to the patient became disconnected. The accused did not notice the disconnection and the patient subsequently suffered a heart attack and died. The accused was charged with manslaughter by gross negligence. He was convicted of the charge and appealed,

Held: the accused was guilty of manslaughter by gross negligence.

Lord Mackay stated:

> The essence of the matter, which is supremely a jury question, is whether, having regard to the risk of death involved, the conduct of the defendant was so bad in all the circumstances as to amount in their judgment to a criminal act or omission.

Lord Mackay also quoted Lord Hewitt CJ—with approval—from *R v Bateman* (1925), who stated:

> …the facts must be such that, in the opinion of the jury, the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving punishment.

14.3 Liability for euthanasia

14.3.1 Actively ending life, even at the patient's request, is murder

R v Cox (1992)

For the facts and decisions, see 6.1.1.

Think point

What is the legal position of a doctor who administers a pain relieving drug knowing that it will shorten the patient's life?

Note

Criminal liability may also arise under abortion law (Chapter 8) and assisting a patient to commit suicide (Chapter 6). See, also, Chapter 9 on mental health law.

15 Control of Communicable Diseases

The control of communicable diseases is largely governed by the Public Health (Control of Disease) Act 1984 and the Public Health (Infectious Diseases) Regulations 1988. Other regulations, such as the Milk and Dairies (General) Regulations 1959, cover particular circumstances. Only the Public Health Act and Regulations will be considered here.

Think point

Control of communicable diseases may involve an infringement of individual rights. Under the HRA 1998, how should the courts determine whether the breaches are justified?

15.1 Notifiable diseases

15.1.1 Section 10 of the Public Health Act 1984 lists the notifiable diseases

In this Act 'notifiable disease' means any of the following diseases—

(a) cholera;
(b) plague;
(c) relapsing fever;
(d) smallpox; and
(e) typhus.

Note

This list has been extended by the 1988 Regulations and includes: meningitis, anthrax, dysentery, diphtheria, measles, mumps, rubella, whooping cough, malaria tetanus, and tuberculosis. The Regulations have extended some of the provisions of the 1984 Act to include AIDS but it is not a notifiable disease in the full sense.

15.1.2 The local authority may direct that other diseases are notifiable

Section 16 of the Public Health Act 1984

(1) A local authority may by order direct that an infectious disease other than one specified in s 10 above or one to which regulations under s 13 above relate shall, for the purpose of the application to their district of such of the provisions of this Act relating to notifiable diseases as are specified in the order, be deemed to be a notifiable disease.

Note

The Secretary of State must approve orders made under this provision (s 16(2)), advertised in a local newspaper and distributed to all registered doctors in their district (s 16(3)). Temporary emergency orders must be advertised (s 16(4)) but will be effective for one month without the Secretary of State's approval although the Secretary of State may revoke the order (s 16(5)).

15.1.3 Cases of notifiable diseases and food poisoning must be reported

Section 11 of the Public Health Act 1984

(1) If a registered medical practitioner becomes aware, or suspects, that a patient whom he is attending within the district of a local authority is suffering from a notifiable disease or from food poisoning, he shall, unless he believes, and has reasonable grounds for believing, that some other registered medical practitioner has complied with this sub-section with respect to the patient, forthwith send to the proper officer of the local authority for that district, a certificate stating—

(a) the name, age and sex of the patient and the address of the premises where the patient is;
(b) the disease or, as the case may be, particulars of the poisoning from which the patient is, or is suspected to be suffering and the date, or approximate date of its onset…

15.2 Control of infection

15.2.1 The Secretary of State may make regulations to control certain diseases

Section 13 of the Public Health Act 1984

(1) Subject to the provisions of this section, the Secretary of state may, as respects the whole of any part of England and Wales, including coastal waters, make regulations—

(a) with a view to the treatment of persons affected with any epidemic, endemic or infectious disease and for preventing the spread of such diseases;
(b) for preventing danger to public health from vessels or aircraft arriving at any place; and
(c) for preventing the spread of infection by means of any vessel or aircraft leaving any place, so far as may be necessary or expedient for the purpose of carrying out any treaty, convention, arrangement or engagement with any other country.

Note

This section has a wider coverage of diseases than those that are simply 'notifiable'.

15.2.2 Putting others at risk may be an offence

Section 17 of the Public Health Act 1984

(1) A person who—

(a) knowing that he is suffering from a notifiable disease, exposes other persons to the risk of infection by his presence or conduct in any street, public place, place of entertainment or assembly, club, hotel, inn or shop;
(b) having the care of a person whom he knows to be suffering from a notifiable disease, causes or permits that person to expose other persons to the risk of infection by his presence or conduct in any such place as aforesaid…

shall be liable on summary conviction to a fine…

Section 19 of the Public Health Act 1984

A person who, knowing that he is suffering from a notifiable disease, engages in or carries on any trade, business or occupation which he cannot engage in or carry on without risk of spreading the disease, shall be liable on summary conviction to a fine…

15.2.3 Children may be excluded from school and places of entertainment

Section 21 of the Public Health Act 1984

(1) A person having the care of a child who—

(a) is or has been suffering from a notifiable disease; or
(b) has been exposed to infection of a notifiable disease;

shall not, after receiving notice from the proper officer of the local authority for the district that the child is not to be sent to school, permit the child to attend school until he has obtained from the proper officer a certificate that in his opinion the child may attend school without undue risk of communicating the disease to others.

Section 23 of the Public Health Act 1984

(2) With a view to preventing the spread of a notifiable disease, a local authority may, by notice published in a manner as they think best for bringing it to the persons concerned, prohibit or restrict the admission of persons under the prescribed age to any place to which this section applies for a time specified in the notice.

Note

Section 23(1) contains a list of applicable venues, which include theatres, cinemas, swimming pools, gyms, outdoor sports facilities, circuses, fairs and fetes.

15.2.4 Infected articles must be dealt with properly

Section 24 of the Public Health Act 1984 states that infected articles should not be sent to a public laundry, but should be properly disinfected. Section 25 proscribes the use of library books by persons infected with a notifiable disease and states that where such a person has come into contact with a library book, that book should be properly disinfected or destroyed.

Section 26 forbids the disposal of infected material into dustbins. Section 27 gives the local authority the power to provide disinfecting stations.

15.2.5 Infected premises must be properly disinfected

Section 28 allows the local authority to forbid any working in premises where a case of a notifiable disease has occurred. Section 29 requires a lessor (s 29(2)) or a hotel/inn keeper (s 29(3)) to ensure that the relevant

room, house or part of a house and the contents are properly disinfected before letting the property. A certificate must be obtained from the local authority or a registered doctor (s 29(4)). Section 30 requires that any person vacating a house or part of a house, which he knows has been occupied within the previous six weeks by a person suffering from a notifiable disease, must ensure the relevant part(s) and contents are properly disinfected or that the owner is notified. Section 31 gives the local authority the power to order the disinfection—at the owner's cost—of any premises and articles if that 'would tend to prevent the spread of any infectious disease'. Section 32 gives the local authority the power to remove healthy persons from an infected house to alternative accommodation. This may be done with their consent (s 32(1)(a)) or without their consent if an order is made by a Justice of the Peace (s 32(1)(b)).

15.2.6 Persons suffering from a notifiable disease must not use public transport

Section 33 of the Public Health Act 1984

(1) No person who knows that he is suffering from a notifiable disease shall—

(a) enter any public conveyance used for the conveyance of persons at separate fares; or
(b) enter any other public conveyance without previously notifying the owner or driver that he is so suffering.

Note

Section 33(2) places a similar responsibility on a person looking after someone with a notifiable disease. Contravention of either section carries a fine and the guilty party may be required to cover any losses incurred by the owner, driver or conductor of the conveyance (s 33(3)).

Section 34 of the Public Health Act 1984

(1) The owner, driver or conductor of a public conveyance…shall not convey in it a person whom he knows to be suffering from a notifiable disease.
(3) If a person suffering from a notifiable disease is conveyed in a public conveyance, the person in charge of the conveyance shall—

(a) as soon as is practicable give notice to the local authority…
(b) before permitting any other person to enter the conveyance, cause it to be disinfected.

15.3 Examination and treatment

15.3.1 A person carrying or infected with a notifiable disease may be required to undergo a medical examination

Section 35 of the Public Health Act 1984

(1) If a Justice of the Peace (acting, if he deems it necessary, *ex parte*) is satisfied, on a written certificate issued by a registered medical practitioner nominated by the local authority for a district—

(a) that there is reason to believe that some person in the district—

(i) is or has been suffering from a notifiable disease; or
(ii) …is carrying an organism that is capable of causing it; and

(b) that it is in his own interest, or in the interest of his family, or in the public interest, it is expedient that he should be medically examined; and
(c) that he is not under the treatment of a registered medical practitioner or that the registered medical practitioner who is treating him consents to the making of an order under his section,

the Justice may order him to be medically examined by a registered medical practitioner so nominated.

Note

This examination includes invasive microbiological testing and any necessary x-rays, etc (s 35(3)). Similar provisions apply to groups of persons (s 36).

15.3.2 A person suffering from a notifiable disease may be removed to or detained in a hospital

Section 37 of the Public Health Act 1984

(1) Where a Justice of the Peace (acting, if he deems it necessary, *ex parte*) is satisfied, on the application of the local authority, that a person is suffering from a notifiable disease and—

(a) that his circumstances are such that proper precautions to prevent the spread of infection cannot be taken, or that such precautions are not being taken; and
(b) that serious risk of infection is thereby caused to other persons; and
(c) that accommodation for him is available in a suitable hospital vested in the Secretary of State,

the Justice may, with the consent of the Area or District Health Authority responsible for the administration of the hospital, order him to be removed toit.

Section 38 of the Public Health Act 1984

(1) Where a Justice of the Peace (acting, if he deems it necessary, *ex parte*)…is satisfied, on the application of any local authority, that an inmate of the hospital who is suffering from a notifiable disease would not, on leaving the hospital, be provided with lodging or accommodation in which proper precautions could be taken to prevent the spread of disease by him, the Justice may order him to be detained in the hospital.
(3) Any person who leaves a hospital contrary to an order made under this section for his detention there shall be liable…to a fine.

15.3.3 Compulsory screening or treatment for communicable diseases may be a justifiable breach of the person's human rights

Acmanne v Belgium (1984) EComHR

The applicants were fined for refusing to allow children in their care undergo compulsory screening for tuberculosis (TB). Four of the applicants were parents and the other six were secondary school teachers. The applicants argued that the law in Belgium—requiring compulsory tuberculin test and chest x-ray—was a breach of Art 8 of the European Convention on Human Rights. Article 8 provides:

1 Everyone has the right to respect for his private and family life, his home and his correspondence.
2 There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

Held: the Commission found that, since even minor medical treatment against the patient's will may breach Art 8, the compulsory screening may amount to an interference with the right to respect for private life. However/the compulsory screening was in accordance with the law, was justified to protect public health, and was 'proportionate to the legitimate aim pursued'. The compulsory screening for TB was therefore allowed as a legitimate derogation under Art 8(2) and so was not a breach of human rights.

Note

Although this applies to screening, the same arguments would probably succeed for both compulsory examinations and treatment of persons with notifiable diseases. Also, while European human rights judgments will not be binding precedents on English courts under the Human Rights Act 1998, the cases will be considered and may be persuasive.

15.4 The death of a person suffering from a notifiable disease

Sections 43–48 regulate the disposal of the body of a person who died while suffering from a notifiable disease. The body must be isolated from unnecessary contact (s 44) and s 45 makes a wake unlawful. Section 47 allows the Secretary of State the power to make regulations relating to the disposal of the deceased's body and s 48 allows a Justice of the Peace the power to order the body to be immediately removed to a mortuary for disposal. Section 46 places the local authority under a duty to ensure that proper arrangements have been made for the disposal of the body and s 43 allows that the local authority may prevent the removal of the body from a hospital except for the purposes of immediate disposal.

15.5 GMC guidance for doctors: Serious Communicable Diseases

15.5.1 Standard of care

(1) All patients are entitled to good standards of practice and care from their doctors, regardless of the nature of their disease or condition.
(2) …where patients pose a serious risk to your health or safety you may take reasonable, personal measures to protect yourself before investigating a patient's condition or providing treatment…
(3) You must keep yourself informed about serious communicable diseases, and particularly their means of transmission and control.

15.5.2 Doctors' responsibilities to protect patients from infection

(24) You must protect patients from unnecessary exposure to infection by following safe working practices and implementing appropriate infection control measures…

(25) You must follow the UK Health Departments' advice on immunisation against hepatitis B. If you are in direct contact with patients, you should protect yourself and your patients by being immunised against other common serious communicable diseases, where vaccines are available.
(26) You must always take action to protect patients when you have good reason to suspect that your own health, or that of a colleague, is a risk to them.

15.5.3 Responsibilities of doctors who have been exposed to a serious communicable disease

(29) If you have any reason to believe that you have been exposed to a serious communicable disease, you must seek and follow professional advice without delay on whether you should undergo testing and, if so, which tests are appropriate…
(30) If you acquire a serious communicable disease, you must promptly seek and follow advice from a suitably qualified colleague—such as a consultant in occupational health, infectious diseases or public health on:

- whether, and in what ways, you should modify you professional practice;
- whether you should inform your current employer, your previous employers or any prospective employer about your condition.

16 Professional Regulation

In addition to the legal system, Healthcare professionals are also subject to regulation by their employers and the professional bodies. The government has also established a new Special Health Authority—the National Clinical Assessment Authority (NCCA)—which will monitor the professional performance of doctors (it is planned to expand this to include all healthcare professionals once the effectiveness of the Authority has been demonstrated). Where the employer has doubts or concerns about the doctor's clinical performance, the matter may be (but does not have to be) referred to the Authority. The Authority, acting as an advisory body, will investigate and make recommendations to the employer. The responsibility for resolving the problem always remains with the employer. The doctor may self-refer to the NCCA if he wishes any doubts about his performance to be resolved (see NHS Executive (2001)).

There are many professional regulatory bodies that oversee the behaviour of practitioners. They exist for doctors, dentists, nurses, midwives and health visitors, opticians, pharmacists, chiropractors, osteopaths, hearing aid suppliers, dieticians, occupational therapists, chiropodists, orthoptists, physiotherapists, radiographers, and medical laboratory technicians. As part of the NHS plan, the government has stated that it intends to incorporate all of the professional regulatory bodies as part of a single body—the UK Council of Health Regulators. This will not do away with the current bodies (although that may change if concern remains about them) to help develop a common approach to professional self-regulation. This chapter will concentrate mostly on the regulation of doctors but some of the main differences with the other bodies will be noted where appropriate.

16.1 Doctors are regulated by the General Medical Council (GMC)

16.1.1 The GMC is a body established by statute with regulatory powers assigned by statute

Section 1 of the Medical Act 1983 (as amended)

1(1) There shall continue to be a body corporate known as the General Medical Council…having the functions assigned to them by this Act.

1(3) There shall continue to be [seven] committees…known as the Education Committee, the Preliminary Proceedings Committee, the Professional Conduct Committee, [the Assessment Referral Committee, the Committee on Professional Performance], the Health Committee [and the Interim Orders Committee] constituted in accordance with Pt III of Sched 1 to this Act and having the functions assigned to them by those Act.

Note

(1) The Medical (Professional Performance) Act 1995 establishes two additional committees: the Assessment Referral Committee and the Committee on Professional Performance; and The Medical Act 1983 (Amendment) Order 2000 establishes the Interim Orders Committee (see 16.3.2, Note (3)).

(2) The GMC was first established by the Medical Act 1858. The equivalent bodies for other health professionals are also established by statute. Thus, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) is governed by the Nurses, Midwives and Health Visitors Act 1979, and the General Dental Council (GDC) by the Dentists Act 1984.

Think point

Should self-regulation of health professionals be replaced by an external regulatory body?

16.1.2 The GMC maintains a register of qualified medical practitioners who are suitable to practice

Section 2 of the Medical Act 1983

2(1) There shall continue to be kept by the registrar of the [GMC] two registers of medical practitioners registered under the Act containing the names of those registered and the qualifications they are entitled to have registered under this Act.

2(3) Medical practitioners shall be registered as fully registered medical practitioners or provisionally or with limited registration as provided in Pts II and III of this Act…

Note

The practice of medicine is not restricted to those registered with the GMC. However, certain areas of practice are so restricted, including the prescribing of certain drugs, abortion (Abortion Act 1967), assisting childbirth (along with registered midwives), the removal of organs or tissue for transplantation (Human Tissue Act 1961), and medical certification (death, sick leave, etc: s 48 of the Medical Act 1983). Under s 47 of the Medical Act 1983, only certain appointments—for example, as prison doctors, or doctors in public hospitals, or doctors in the armed forces—can be held by registered practitioners.

16.1.3 It is a criminal offence to pretend to be registered as a practitioner

Section 49 of the Medical Act 1983

49(1) Subject to sub-section (2) below, any person who wilfully and falsely pretends to be or takes or uses the name or title of physician, doctor of medicine, licentiate in medicine and surgery, bachelor of medicine, surgeon, general practitioner or apothecary, or any name, title, addition or description implying that he is registered under any provision of this Act, or that he is recognised by law as a physician or surgeon…shall be liable on summary conviction to a fine…

16.1.4 The GMC regulates the registration of overseas doctors

Section 19 of the Medical Act 1983

19 (1) Where a person satisfies the Registrar—

(a) that he holds one or more recognised overseas qualifications;

(b) that he has the necessary knowledge of English; and

(c) that he is of good character,

and satisfies the requirements of s 20 below as to experience, that person shall, if the…[GMC] think fit so to direct, be registered under this section as a fully registered medical practitioner.

Note

Similar requirements apply, by virtue of s 22 to the limited registration of overseas doctors. Under ss 17 and 18, these provisions do not apply to

doctors from other EC Member States, who may obtain registration by providing evidence that they are certified to practice in their own country, or that they have obtained a medical qualification certified by the medical authorities of their country. (Similarly, for nurses, overseas qualifications must be recognised by the UKCC—s 14 of the Nurses, Midwives and Health Visitors Act 1979.)

16.2 The GMC oversees and determines educational standards

16.2.1 The GMC determines the standard of qualifying exams

Section 5 of the Medical Act 1983

5(1) The Education Committee shall have the general function of promoting high standards of medical education and co-ordinating all stages of medical education.

5(2) For the purpose of discharging that function, the Education Committee shall—

(a) determine the extent of the knowledge and skill which is to be required for the granting of primary United Kingdom qualifications and secure that the instruction given in universities in the United Kingdom to persons studying for such qualifications is sufficient to equip them with knowledge and skill of that extent;

(b) determine the standard of proficiency which is to be required from candidates at qualifying examinations and secure the maintenance of that standard…

Note

Under s 7, the Education Committee may appoint visitors to report 'as to the sufficiency of the instruction' at medical schools. Under s 9, if the Educational Committee believes that a particular course of study/examination is no longer suitable, they can make representation to the Privy Council (PC) which may disqualify that course/examination.

16.3 The GMC regulates professional conduct

16.3.1 The GMC may advise on medical ethics and standards of practice

Section 35 of the Medical Act 1983 (as amended)

The powers of the General Council shall include the power to provide, in such a manner as the Council think fit, advice for members of the medical profession on standards of professional conduct [or performance] or on medical ethics.

Note

Guidance is published by the GMC in a number of booklets. General guidance is provided in the booklet entitled *Good Medical Practice* (1998). It states: 'Being registered with the GMC gives you rights and privileges. In return you must fulfil the duties and responsibilities of a doctor set out by the GMC.'

The principles of good medical practice and the standards of competence, care and conduct expected of you in all aspects of your professional work, are described in this booklet. They apply to all doctors involved in healthcare.

If serious problems arise which call your registration into question, these are the standards against which you will be judged. Thus: 'All patients are entitled to good standards of practice and care from their doctors. Essential elements of this are professional competence; good relationships with patients and colleagues; and observance of professional ethical obligations.'

The equivalent publication produced by the UKCC is *Guidelines for Professional Practice* (1996). This states: 'The role of the UKCC in protecting the public is firstly to maintain a register of people it deems to be suitable practitioners and who have demonstrated knowledge and skill through a qualification registered with the UKCC. Secondly, it may remove people from the register either because they are seriously ill or because a charge of misconduct has been proven against them. The Code (Code of Professional Conduct (1992)) is used as the standard against which a complaint is considered.'

16.3.2 The GMC may erase, suspend or place conditions on the registration of a practitioner found guilty of serious professional misconduct or a criminal offence

Section 36 of the Medical Act 1983 (as amended)

36(1) Where a fully registered person—

(a) is found by the Professional Conduct Committee to have been convicted in the British Islands of a criminal offence [or to have been convicted elsewhere

of an offence which, if committed in England and Wales, would constitute a criminal offence], whether while so registered or not; or

(b) is judged by the Professional Conduct Committee to have been guilty of serious professional misconduct, whether while so registered or not;

the Committee may, if they think fit, direct—

(i) that his name shall be erased from the register;
(ii) that his registration shall be suspended…during such period not exceeding 12 months as may be specified in the direction; or
(iii) that his registration shall be conditional on his compliance, during such period not exceeding three years as may be specified in the direction, with such requirements so specified as the Committee think fit to impose for the protection of the public or in his interests.

Note

(1) Section 36(3) allows extension of a suspension for periods of up to 12 months. Conditional registration may be similarly extended by virtue of s 36(4). However, there must be a positive and specific reason for the Professional Conduct Committee to consider extending the suspension. It is insufficient to extend the suspension because the original penalty was too lenient or for punitive reasons because the doctor seems insufficiently penitent. See *Taylor v GMC* (1990). If a doctor's name is erased from the register, he must now wait five years before applying for restoration: Art 9 of the The Medical Act 1983 (Amendment) Order 2000.

(2) Nurses, mid wives and health visitors may be erased from the register if they are found guilty of 'professional misconduct' which is defined as 'conduct unworthy of a nurse, midwife or health visitor' (r 1(2)(k) of the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993). Under s 9(1)(b) of the Professions Supplementary to Medicine Act 1960, prohibited behaviour is still described as 'infamous'. However, in *R v General Council of Medical Education & Registration of the UK* (1930) 'infamous' was considered to be more aptly defined as 'serious misconduct in a professional respect'.

(3) Where a doctor faces sufficiently serious allegations, the Interim Orders Committee may make an order suspending the doctor's registration for up to a maximum period of 18 months. The order must be reviewed within the first six months and then, at least, every three months. These procedures are contained in s 41A inserted into the Medical Act 1983 by Art 10 of the Medical Act 1983 (Amendment) Order 2000. See, also, The GMC, *Interim Orders Committee: Referral Criteria*, 2000; The General Medical Council (Interim Orders Committee) (Procedure) Rules Order of Council 2000.

16.3.3 It is the duty of the Professional Conduct Committee to ensure that any penalty imposed because of a criminal conviction is appropriate to the nature and gravity of the crime committed

Spofforth v General Dental Council (1999) PC

The appellant had been convicted of seven counts of forgery and false accounting amounting to £5,826. The convictions related to falsified invoices required to support a claim for certain grant monies. There was no allegation that he had not incurred the expenditure or would not have been entitled to the grant, he had simply failed to keep the required proof which he subsequently forged. The only sanction available to the GDC under s 27 of the Dentists Act 1984 was to erase his name from the register. The GDC refused leave for adjournment despite the fact that S was suffering from profound depression and unable to give proper instructions for the conduct of his case. The dentist appealed.

Held: appeal allowed. The Professional Conduct Committee had a duty to satisfy itself that any criminal convictions were so grave as to demonstrate that the dentist was unfit to practise before resorting to the sole and draconian power of erasure from the register. Since none of his patients had suffered and there had been no improper claims on the NHS, the appellant had a case to make before the GDC and there was no good reason for refusing his request for adjournment.

Note

This does not necessarily apply to all the professions. Nurses may be disciplined simply for professional misconduct and their rules of conduct allow that any criminal conviction may amount to such. See *Balamoody v UKCC For Nursing Midwifery and Health Visiting* (1998). But, conviction of a crime does not require a finding of professional misconduct, which is for the Professional Conduct Committee to determine. See r 16(7) of the Nurses, Mid wives and Health Visitors (Professional Conduct) Rules 1993.

Dad v General Dental Council (2000) PC

The appellant had been twice convicted of offences under the Road Traffic Act 1988. As a consequence of this, the GDC suspended the appellant's registration for 12 months. The Professional Conduct Committee (PCC) considered that his behaviour might bring the profession into disrepute or undermine public confidence. The appellant submitted that the penalty was harsh and unjustified.

Held: appeal allowed. The PC would be slow in interfering with the PCC on a particular penalty. But, the disciplinary procedures of the GDC were to protect the public and maintain professional standards and not to punish individuals for a second time. The PCC must consider the nature and gravity of the convictions. The offences had been committed at the weekend, were unconnected with the dentist's work, there was a real possibility of rehabilitation and there were no other grounds for doubting his fitness to practice. A more suitable penalty would have been postponement for two years to allow the appellant time to demonstrate that he was capable of refraining from committing further offences under the Road Traffic Act 1988.

16.3.4 Moral impropriety may amount to serious professional misconduct

Jeetle v GMC (1995) PC

The appellant had behaved indecently and entered into a sexual relationship with one of his patients. The patient complained to the police and the appellant was discovered naked in the patient's bedroom by two police officers. One of the charges before the GMC was that the doctor had prescribed opiates for his patient in order to facilitate his sexual advances. The appellant was found guilty of serious professional misconduct and his name was erased from the register. He appealed on the grounds that the allegation regarding the reason for his prescribing the drugs was not stated in the charge and there was no direct finding.

Held: appeal dismissed. Whether or not the drugs had been prescribed to facilitate sexual advances, the Professional Conduct Committee had sufficient grounds to justify their finding of serious professional misconduct.

Note

One of the duties required of doctors by the GMC is that they 'avoid abusing [their] position as a doctor'. In *De Gregory v GMC* (1961), a doctor was struck off for serious professional misconduct when he began a relationship with a married woman. The woman and her family had been the doctor's patients but prior to the relationship becoming physical the woman removed herself (although not her children) from the doctor's list. Despite the woman not being the doctor's patient, the PC upheld the GMC's finding of serious professional misconduct because 'he gained his access to the home in the first place by virtue of his professional position'.

Think point

Should healthcare professionals be disciplined for starting a relationship with a patient?

16.3.5 Serious professional misconduct is not restricted to 'dishonesty or moral turpitude'

Doughty v General Dental Council (1988) PC

The Professional Conduct Committee of the General Dental Council (GDC) found the plaintiff dentist guilty of serious professional misconduct. The charges against him were that he had failed to retain patients' x-rays for a reasonable period and failed to submit them to the Dental Estimates Board when required; he failed to exercise a proper degree of skill when treating patients; and, on a number of occasions, he failed to complete treatment to the patient's satisfaction. The GDC held that his name should be erased from the register. The appellant appealed to the Privy Council.

Held: appeal dismissed.

Their Lordships stated:

> …what is now required is that the General Dental Council should establish conduct connected with his profession in which the dentist concerned has fallen short, by omission or commission, of the standards of conduct expected among dentists and that such falling short as is established should be serious.

Note

This case established an objective standard as one 'judged by proper professional standards in the light of the objective facts about the individual patients…the dental treatments criticised as unnecessary [were] treatments that no dentist of reasonable skill exercising reasonable care would carry out'.

McCandless v GMC (1996) PC

The appellant was found guilty of serious professional misconduct for making diagnostic errors for three patients and for failing to refer them to hospital. The Professional Conduct Committee directed that his name should be erased from the register. He appealed to the Privy Council.

Held: appeal dismissed. 'Serious professional misconduct was not restricted to conduct which was morally blameworthy but could include seriously negligent treatment measured by objective standards.' Their Lordships approved Doughty and held that it also applied to doctors.

Note

A single act that satisfies this standard of 'serious negligence' may be sufficient to incur liability for serious professional misconduct. Thus, in one case, an anaesthetist who failed to obtain the patient's consent for the use of a rectal suppository inserted while the patient was anaesthetised was guilty of serious professional misconduct (see Mitchell (1995). See, also, *R v Statutory Committee of the Pharmaceutical Society of Great Britain ex p Sokoh* (1986)).

16.3.6 The misconduct complained of must be related to the profession of medicine

Roylance v GMC (1999) PC

The appellant was the Chief Executive Officer of the United Bristol Healthcare NHS Trust. He was also a registered doctor. The appellant was charged with failing to take remedial action on being made aware of an excessively high mortality rate of children undergoing corrective heart surgery. He was found guilty of serious professional misconduct and his name was erased from the medical register. One of the grounds of his appeal was that the allegations against him did not concern his professional judgment as a doctor and was therefore not capable of being professional misconduct under s 36 of the Medical Act 1983.

Held: appeal dismissed. There was a sufficiently close link between the duties of a Chief Executive and the profession of medicine since both required a duty to care for the safety and well being of the patients in his charge.

Clyde LJ stated:

> Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word 'professional' which links the misconduct to the profession of medicine. Secondly, the misconduct is qualified by the word 'serious'. It is not any professional misconduct which will qualify. The professional misconduct must be serious.

16.3.7 The standard of proof required is the criminal standard of beyond reasonable doubt

Brown v General Dental Council (1990) PC

A nine year old boy died following a prolonged anaesthetic. The dentist was charged with administering an overdose. He was found guilty of serious professional misconduct and his name was erased from the register. He appealed.

Held: appeal allowed. The prosecution had failed to show, on the criminal standard of proof, that an overdose had been administered or that the appellant had failed to adequately monitor the patient or exercise proper skill.

See, also, *De Gregory v GMC* (1961), in which their Lordships held: 'A high standard of proof is required, and judgment should not be given on a mere balance of probabilities.'

Note

In the *NHS Plan,* the government suggested that the GMC should consider introducing a civil burden of proof.

16.3.8 Where there is a conflict of evidence, it is for the Professional Conduct Committee and not for the preliminary screener or the Preliminary Proceedings Committee to determine that the case cannot succeed

R v GMC ex p Arpad Toth & Jarman (Interested Party) (2000)

Mr Toth accused Dr Jarman of serious professional misconduct after his child died. The screener decided that because there was a conflict of evidence between the doctor and Mr Toth there was no chance of the charge satisfying the criminal standard of proof. The screener therefore decided that there was no question of serious professional misconduct. The GMC accepted that the screener's decision had not followed proper procedure and was legally flawed. They were prepared to consent to an order quashing the decision. Dr Jarman objected that this would be unfair to him.

Held: Mr Toth had a legitimate interest in obtaining an investigation that was not outweighed by any adverse effects or unfairness to Dr Jarman. It was not for the screener or the Preliminary Proceedings Committee (PPC) to determine the likelihood of success based on conflicting evidence. The screener and the PPC should be slow to halt proceedings and any doubt should be resolved in favour of proceeding. The screener's decision would be quashed and the complaint remitted to a different screener.

Note

The role of the screener is to act as a filter to prevent inappropriate cases from proceeding. Once past the screener, the role of the Preliminary Proceedings Committee is to determine whether any case 'ought to be referred for inquiry' to the PCC or the Health Committee (s 42 of the Medical Act 1983). Thus, their role is to determine if the charges are capable of amounting to serious professional misconduct or unfitness to practise and not to consider the likelihood of success based on the evidence.

16.3.9 The GMC must follow the rules of natural justice

GMC v Spackman (1943) PC

In divorce proceedings involving one of his patients, it was found that Dr Spackman had entered into an adulterous relationship with one of his patients. The GMC removed his name from the medical register on the basis of the divorce court's finding. The GMC refused to allow Dr Spackman the opportunity to introduce evidence to controvert that finding. Dr Spackman applied for certiorari.

Held: application allowed. The GMC had failed to satisfy the requirements of natural justice.

Note

Such a refusal would today also fall foul of Art 6 (the right to a fair trial) of the Human Rights Act 1998. However, in *R v UKCC ex p Tehrani* (2001), the Outer House held that, under Art 6 (right to a fair trial), Sched 1 to the HRA 1998, the conduct committee of the UKCC was not required to meet all the conditions of an independent and impartial tribunal because there was an automatic right of appeal to the Court of Session.

16.3.10 The GMC may suspend or place conditions on the registration of a practitioner who is unfit to practise through illness

Section 37 of the Medical Act 1983

37(1) Where the fitness to practise of a fully registered person is judged by the Health Committee to be seriously impaired by reason of his physical or mental condition, the Committee may, if they think fit, direct—

(a) that his registration in the register shall be suspended…during such a period not exceeding 12 months as may be specified in the direction; or

(b) that his registration shall be conditional on his compliance, during such a

period, not exceeding three years as may be specified in the direction, with such requirements so specified as the Committee think fit to impose for the protection of members of the public or in his interests.

Note

If the practitioner fails to comply with the conditions, the GMC may suspend his registration (s 37(2)). Suspension or conditional registration may be extended for periods up to 12 months at a time (s 37(3) and (4)) The Medical (Professional Performance Act 1995 inserts s 37(3A) which allows the Health Committee to extend the suspension indefinitely if the suspension has already been in existence for two years.

16.3.11 The GMC may suspend or place conditions on the registration of a practitioner whose performance is seriously deficient

Section 36A of the Medical Act 1983 (as amended by s 1 of the Medical (Professional Performance) Act 1995

36A(1) Where the standard of professional performance of a fully registered person is found by the Committee on Professional Performance to have been seriously deficient, the Committee shall direct—

(a) that his registration…shall be suspended…during such period not exceeding 12 months as may be specified in the direction; or
(b) that his registration shall be conditional on his compliance, during such period not exceeding three years as may be specified in the direction, with the requirements so specified.

Note

Under s 36A(2) a failure to comply with conditional registration allows the Committee to suspend registration. Suspension from the register can be extended for periods of up to 12 months by virtue of s 36A(3). Section 36A(4) allows the Committee to extend the suspension indefinitely where the suspension has already existed for two years and is within two months of the expiry of the suspension. Section 36A(5) allows the indefinitely suspended practitioner to request a review of the suspension at two yearly intervals.

Note

Sub-section (1) requires the GMC to penalise a doctor whose performance is seriously deficient. This is a statutory requirement and not discretionary. Sub-sections (2)–(4) are discretionary powers. Sub-section (5) again is a statutory requirement that is not discretionary.

Note

There are four stages to the procedure which is a complex investigative and consensual procedure requiring the co-operation of the doctor. Stage 1: screening by the GMC 'preliminary screener'. Stage 2: assessment of performance. If the doctor refuses to co-operate, the Assessment Referral Committee can determine if assessment is justified and can require the doctor to co-operate. Stage 3: remedial action and reassessment. Depending on this stage, the case may progress to Stage 4: referral to the Committee on Professional Performance.

16.4 Appeals against GMC disciplinary decisions

16.4.1 There is a right to appeal to the Privy Council

Section 40 of the Medical Act 1983 (as amended)

(1) The following decisions are appealable decisions for the purposes of this section, that is to say—

(a) a decision of the Professional Conduct Committee under s 36 above giving a direction for erasure, for suspension or for conditional registration or varying the conditions imposed by a direction for conditional registration; or
[(aa) of the Committee on Professional Performance under s 36A above giving a direction for suspension or for conditional registration]; or
(b) a decision of the Health Committee under s 37 above…; or
(c) a decision of the General Council under s 39 above giving a direction for erasure; [or
(d) a decision of the Professional Conduct Committee under s 41(6) giving a direction that the right to make further applications under that section shall be suspended indefinitely; or
(e) a decision of the General Council under s 45(6) giving a direction that the right to make further applications under that section shall be suspended indefinitely].

Note

Section 39 allows erasure from the register where the registration was obtained by fraud or in error.

16.4.2 Appeal from decisions of the Health Committee must be on a question of law

Section 40 of the Medical Act 1983 (as amended)

(5) No appeal under this section shall lie from a decision of the [Committee on Professional Performance or the] Health Committee except on a question of law.

Graf v GMC (1998) PC

The Health Committee suspended the appellant's registration for a period of 12 months. He appealed on the ground that he was not suffering from a mental illness sufficient to seriously impair his fitness to practice within the meaning of s 37 of the Medical Act 1983.

Held: appeal dismissed. There was no issue of law or procedure. The question of mental unfitness was for the Health Committee to decide and their Lordships would not interfere with that decision.

16.4.3 Appeals to the Privy Council are not simply opportunities to rehear the case

Libman v GMC (1972) PC

The appellant had sexual intercourse with one of his patients—whose medical condition was partly psychological—and subsequently offered his patient and her husband sums of money to persuade them not to pursue the issue with the GMC. The Disciplinary Committee found him guilty of serious professional misconduct and suspended his name from the register for six months. He appealed under s 36(3) of the Medical Act 1956 (as amended by s 14 of the Medical Act 1969).

Held: appeal dismissed. The appeal was basically against the findings of the Committee on a question of fact. There was ample evidence to justify their decision.

Their Lordships determined that: '…although the jurisdiction conferred by statute is unlimited, the circumstances in which it is exercised in accordance with the rules approved by Parliament are such as to make it difficult for an appellant to displace a finding or order of the amity unless it can be shown that something was clearly wrong either (i) in the conduct of the trial or (ii) in the legal principle applied or (iii) unless it can be shown that the findings of the committee were sufficiently out of tune with the evidence to indicate with reasonable certainty that the evidence had been misread.'

See, also, *Hossack v GDC* (1998), in which the PC held that they could reverse a finding of fact of the GDC Professional Conduct Committee if that finding of fact was out of tune with the evidence to the extent that the evidence must have been misunderstood. Also, in *Balfour v The Occupational Therapists Board* (2000), the PC held that to find someone guilty of infamous conduct in a professional respect was a question of fact and degree. This was for the Disciplinary Committee to decide and the court would not replace the Committee's decision with its own opinion.

Glossary

A v C	Surrogate mum
A v National Blood Authority	Infected blood
Acmanne v Belgium	Compulsory x-rays
Airedale NHS Trust v Bland	Hillsborough casualty
A NHS Trust v D	Treatment withheld
Allied Maples Group Ltd v Simmons	Negotiating terms
Appleton v Garrett	Greedy dentist
Ashcroft v Mersey RHA	Paralysed face
Associated Provincial Picture Houses v Wednesbury	Irrationality
Attorney General's Reference (No 6 of 1980)	Fight
Attorney General's Reference (No 3 of 1994)	Antenatal killing
Attorney General v Able	Encouraging suicide
Attorney General v Guardian Newspapers (No 2)	The 'Spycatcher' case
B v B (A Minor) (Residence Order)	Grandmother
B v Barking, Havering & Brentwood NHS Trust	Detention reviewed
B v Croydon HA	Self-harm
Bagley v North Herts HA	Death in-utero
Balamoody v UKCC	Criminal conduct
Balfour v The Occupational Therapists Board	False registration
Barnett v Chelsea and Kensington HMC	Poisoned tea
Bernier v Sisters of Service	Frostbite
Blyth v Bloomsbury HA	Question time
Bolam v Friern HMC	Responsible doctors
Bolitho v City and Hackney HA	The unseen patient

Bone v MHRT	Giving reasons
Breen v Williams	Access to notes
Brown v General Dental Council	Dental anaesthetic
Brusnett v Cowan	Muscle biopsy
Bull v Devon AHA	Split site
Burton v Islington HA	Fetus as victim
C v C	Confidential divorce
C v S	Born alive
Cambridgeshire CC v R (An Adult)	Sex offender
Canterbury v Spence	Prudent patient
Capital and Counties plc v Hampshire CC	Fire brigade
Carver v Hammersmith & Queen Charlotte's Special HA	Cost of disability
Cassidy v Ministry of Health	Stiff fingers
Chatterton v Gerson	Real consent
Clark v MacLennan	Stress incontinence
Collins v Hertfordshire CC	Injecting cocaine
Cornelius v De Taranto	Medico-legal report
Council of Civil Service Unions v Minister for Civil Service	Judicial review
Crawford v Board of Governors of Charing Cross Hospital	Continuing education
Crossmann v Stewart	Eye damage
Cull v Butler	Abortive hysterectomy
Curran v Bosze	Sibling doctors
D v UK	Dignified death
Dad v General Dental Council	Driving offences
Davis v Barking, Havering and Brentwood HA	Caudal
Davis v City and Hackney HA	Disabled limitation
DeFreitas v O'Brien	Chronic pain
De Gregory v GMC	Professional access
Denton v South West Thames RHA	Equipment check

Dept of Health v JWB and SMB	Consent 'down under'
Devi v West Midlands RHA	Unwanted sterilisation
Dobson v North Tyneside HA	Brain matter
Donoghue v Stevenson	Decomposing snail
Doodeward v Spence	Body parts
Doughty v General Dental Council	Dental misconduct
Duncan v Medical Practitioners Disciplinary Committee	Dangerous bypass
East African Asians v UK	Degrading people
Edgar v Lamont	Careless amputation
Emeh v Kensington and Chelsea and Westminster AHA	Unreasonable abortion
F v West Berkshire HA	Necessary sterilisation
Fraser v Evans	Confidential public relations
Freeman v Home Office	Voluntary consent
Freeman v Home Office (No 2)	Prison consent
Frenchay Healthcare NHS Trust v S	PVS emergency
Furniss v Flitchett	Wife's psychiatric problems
Gillick v West Norfolk and Wisbech AHA	Teenage sex
Glass v Cambridge HA	Peroxide death
GMC v Spackman	Natural justice
Gold v Essex County Council	Radiation burns
Gold v Haringey HA	Failed sterilisation
Goodwill v British Pregnancy Advisory Service	Future partners
Graf v GMC	Sick doctor
H v Norway	Fetal right to life
Halushka v University of Saskatchewan	Medical research
Hatcher v Black	The wise doctor
Hay v University of Alberta	Confidential law suit
Headford v Bristol and District HA	Continuing disability

Heil v Rankin	Damages
Hepworth v Kerr	Spinal stroke
Herczegfalvy v Austria	Therapeutic necessity
Hills v Potter	Stiff neck
Hotson v East Berkshire HA	Fall from tree
Hossack v GDC	Matter of fact
Hucks v Cole	Septic spot
Hunter v Hanley	Broken needle
Hunter v Mann	Driving offence
Hurtado v Switzerland	No treatment degrades
Janaway v Salford HA	Conscientious objection
Jeetle v GMC	Doctor-patient relationship
Jones v Manchester Corporation	Staff supervision
Kelly v Kelly	The fetus and his father
Kent v Griffiths	Slow ambulance
Kenyon v Bell	Loss of sight
LCB v UK	Radiation effects
Libman v GMC	Sexual misconduct
Loveday v Renton	Vaccine damage
Lybert v Warrington HA	Hysterectomy
Mallette v Shulman	Jehovah's Witness
Maynard v West Midlands RHA	TB diagnosis
McCandless v GMC	Medical misconduct
McFarlane v Tayside HB	Wrongful birth
McGhee v National Coal Board	Brick dust
McKay v Essex AHA	Wrongful life
Mink v University of Chicago	Battered women
Mohr v Williams	Wrong ear
Mold v Hayton and Newson	Late diagnosis
Moore v Regents of the University of California	That's my spleen

Nancy B v Hotel-Dieu de Quebec	Right to die
Newell and Newell v Goldenberg	Failed vasectomy
NHS Trust A v Mrs M; NHS Trust B v Mrs H	Withdrawal of feeding
Nicholson v Halton General Hospital NHS Trust	Work related injury
Norfolk and Norwich Healthcare (NHS) Trust v W	Forced labour
North West Lancashire HA v A, D & G	Sex change
Osman v UK	Police liability
Papadimitropolous v R	Not really married
Paton v BPAS Trustees	Father of the fetus
Paton v UK	Fetal rights
Pearce v United Bristol Healthcare NHS Trust	Stillbirth
Perkins v Bath DHA and Wiltshire CC	Invalid reasons
Pippin v Sheppard	Inflamed wound
Powell v Boldaz	Relative duty
Pridham v Nash	Adhesions
R v Adomoko	The gas man
R v Ashworth HA ex p Brady	Moors murderer
R v Bateman	Criminal negligence
R v Bodkin Adams	Double effect
R v Bolduc and Bird	Voyeur
R v Bournewood NHS Trust ex p L	Informal care
R v Brown	Sadomasochism
R v Cambridge DHA ex p B	Child B case
R v Cannons Park MHRT ex p A	Treatability
R v Central Birmingham HA ex p Walker	Hole in the heart
R v Clarence	Venereal disease
R v Cox	Active euthanasia

R v DoH ex p Source Informatics	Anonymised prescriptions
R v Dhingra	Post-coital contraception
R v Ealing DHA ex p Fox	After care
R v East London & City Mental Health NHS Trust ex p Von Brandenburg	Back in detention
R v Ethical Committee of St Mary's ex p Harriott	Infertile prostitute
R v GCMER	Infamous conduct
R v Gloucestershire CC ex p Barry	Needs of the disabled
R v GMC ex p Toth & Jarman	The screener
R v Hallstrom ex p W; R v Gardner ex p L	Community care
R v Horseferry Road Justices ex p IBA	It's not criminal
R v HFEA ex p Blood	Life after death
R v Kelly	Artistic organs
R v Lennox Wright	Breach of Statute
R v Malcherek; R v Steel	Medical death
R v McShane	Drugs and alcohol
R v MHAC ex p Smith	Hearing complaints
R v MHAC ex p X	Sex drive
R v MHRT ex p Clatworthy	Sexual deviant
R v MHRT ex p H	Unlawful detention
R v MHRT ex p Hall	Conditional discharge
R v Mid-Glamorgan FHSA ex p Martin	The harm of self-knowledge
R v North and East Devon HA ex p Coughlan	Nursing home
R v North Derbyshire HA ex p Fisher	Blanket ban
R v Portsmouth NHS Trust ex p Glass	Breaking glass
R v Price	Knowledge of pregnancy
R v Richardson	Struck-off dentist
R v Rothery	Taking blood
R v S o S for Social Services ex p Hincks	Shelved plans
R v Secretary of State for Health ex p Pfizer	Viagra
R v Smith	Illegal abortion
R v Statutory Com of Pharmaceutical Soc ex p Sokoh	Once is enough

R v Tabassum	Breast examination
R v UKCC ex p Tehrani	Impartial tribunal?
R v Welsh	Theft of urine
R v Woollin	Criminal intent
Rance v Mid-Downs HA	Abortive desire
Rand v East Dorset HA	Disabled birth
R-B v Official Solicitor	A snip in time
Re A	Legal death
Re A (Children) (Conjoined Twins: Surgical Separation)	Siamese twins
Re A (Male Sterilisation)	Down's adult
Re Adoption Application (Payment for Adoption)	Adoption expenses
Re AK	Blinking eyes
Re B	The Jeanette case
Re B (A Minor) (Wardship: Medical Treatment)	Down's baby
Re C (A Minor)	Surrogate ward
Re C (Adult: Refusal of Treatment)	Competent schizophrenic
Re C (Adult Patient: Publicity)	Post mortem confidence
Re C (A Child) (HIV Testing)	Baby AIDS
Re D (A Minor)	Drug dependent baby
Re D (Medical Treatment)	No meaningful life
Re E (A Minor) (Wardship: Medical Treatment)	Teenage Jehovah's Witness
Re F (In-Utero)	Warding the fetus
Re F (A Child) (Care Order: Sexual Abuse)	Return to abuse
Re F (Adult: Court's Jurisdiction)	Residency order
Re GF (Medical Treatment)	Heavy periods
Re H (Mental Patient: Diagnosis)	Brain tumour
Re H (A Minor) (Blood Tests: Parental Rights)	Father's rights
Re J (A Minor) (1990)	Dictating treatment
Re J (A Minor) (1992)	Baby J

Re K, W and H (Minors) (Medical Treatment)	Parental consent
Re LC (Medical Treatment: Sterilisation)	Sterilised abuse
Re M (Child: Refusal of Medical Treatment)	Heart of the matter
Re MB (Medical Treatment)	Pregnant needle phobic
Re O (A Minor) (Blood Tests: Constraint)	Paternity test
Re P (A Minor)	Teenage pregnancy
Re P (Minors)	Surrogate children
Re P	Reversible sterilisation
Re Q (Parental Order)	Costs of surrogacy
Re R (A Minor) (Wardship: Consent to Treatment)	Key holder
Re R (Adult: Medical Treatment)	Low awareness state
Re R (A Minor) (Blood Test: Constraint)	To test or not to test
Re S	Fetal protection
Re S (A Minor) (Medical Treatment)	Jehovah's parents
Re S (Hospital Patient: Court's Jurisdiction)	Tug of war
Re S (Adult Patient: Sterilisation)	Best contraception
Re S-C (Mental patient: Habeas Corpus)	Challenging procedure
Re SG (Adult Mental Patient: Abortion)	Necessary termination
Re T (Adult: Refusal of Medical Treatment)	Pregnant blood transfusion
Re T (A Minor) (Wardship: Medical Treatment)	Liver transplant
Re W (A Minor) (Medical Treatment)	Legal 'flak jacket'
Re Y (Adult Patient) (Transplant: Bone Marrow)	Best interests transplant
Re Z	Private schooling
Re ZM & OS (Sterilisation: Best Interests)	Doctors in conflict
Reibl v Hughes	Negligent disclosure
Reisner v Regents of the University of California	HIV risk
Robertson v Nottingham HA	Birth trauma
Rochdale Healthcare (NHS) Trust v C	Labouring woman
Roe v Ministry of Health	Cracked ampoules
Rogers v Whitaker	Aussie prudent patient

Royal College of Nursing of UK v DHSS	Doctor's orders
Royal Wolverhampton Hospitals NHS Trust v B	The Doctor's prerogative
Roylance v GMC	Bristol heart doctor
S v McC; W v W	Father's interest
Sabri-Tabrizi v Lothian HB	Failed sterilisation
Saunders v Leeds Western HA	Air embolus
Schloendorff v Society of New York Hospital	American autonomy
Scott v London and St Katherine Docks Co	Sugar hit
Secretary of State for the Home Department v Robb	Hunger strike
Sidaway v Governors of Bethlem Royal Hospital	Nerve damage
Smith v Salford HA	Paralysing operation
Smith v Tunbridge Wells HA	Impotence
Spofforth v General Dental Council	Dental forgery
SW Hertfordshire HA v KB	Feeding the anorexic
St Georges Healthcare NHS Trust v S	Pregnancy rights
Stephens v Avery	Lesbian relationship
Stovin v Wise	Dangerous junction
Strunk v Strunk	Kidney transplant
Tarasoff v Regents of the University of California	Duty to warn
Taylor v GMC	Insufficient penitence
Thameside and Glossop Acute Services Trust v CH	Forced caesarean
Thake v Maurice	Failed vasectomy
Thor v Superior Court	State interests
Tredget v Bexley HA	Newborn death
Venner v North East Essex HA	Stopping the pill

W v Edgell	Public danger
W v L	Animal torture
W v UK	Children in care
Walkin v South Manchester HA	Conception starts the clock
Watson v M'Ewan	Witness immunity
White v Turner	Breast scars
Whitehouse v Jordan	Difficult birth
Williams v Williams	Not your corpse
Winiewski v Central Manchester HA	Fetal distress
Wilsher v Essex AHA	Blind baby
Worster v City & Hackney HA	Consent forms
X v FRG	In his best interests
X v Y	AIDS disclosure

Think Point Hints

1.1.1 Bear in mind that utilitarianism is based on the principle of maximisation of happiness and equal weight must be given to each person's happiness. This allows one individual to gain at the expense of another providing the overall happiness is increased. The situation may be altered under 'rule utilitarianism'.

1.2.2 This question asks you to consider whether healthcare workers owe a duty to rescue outside of their working environment. Relevant points include whether there is a general obligation to rescue and what the extent of that obligation is, for example, does it include putting oneself at risk? Also, is the choice to be a healthcare worker simply a choice of job or is it a philosophical choice that demonstrates an intention to live one's life according to a certain code (compare with a priest)? Are all healthcare workers under the same obligation?

1.2.4 Are moral duties absolute? How does one determine the 'correct' choice when two moral duties conflict? What if telling a lie to a patient would protect them from harm? But, what counts as harm and who should determine whether the harm caused by telling a lie is less than the harm prevented? Does a lie automatically cause harm? Can you lie and still respect the other person's autonomy?

1.7.4 Think about the values and goals of medicine. Should the situation be affected by whether the patient's, or doctor's, beliefs are compatible with the values adopted by the healthcare profession as a whole? When should a healthcare professional be allowed to conscientiously object and withdraw from caring for the patient (for example, abortion)? If the healthcare worker is justified in withdrawing, what are his remaining obligations to the patient?

2.2.5 Think about whether the purpose for which a procedure is performed is important to its 'nature'? Is purpose a necessary piece of information? Does the concept of sectionalisation apply in this situation? Does it make any difference if the purpose is a recognised medical purpose or one that the courts might consider immoral? If you consent to an examination believing it to be diagnostic, would the court decide the consent was invalid if the examination had a sexual motive? Consider *Appleton*, *Richardson*, and *Tabassum*.

2.3.1 Think about the difference between coercion and inducement. Consider the status quo position: is the offer to make a person's situation better if they consent morally different to a threat to make that person's situation worse unless they consent? Is it acceptable if I offer you £10 to consent to a blood donation? Can an inducement ever exert so much pressure as to be morally wrong? Consider the situation of offering money to a homeless destitute person in exchange for a kidney.

2.3.2 Did the presence of a bystander affect the 'nature' of the act performed or was it merely collateral? Remember that the identity of the actor may also be important: see *Tabassum*. But here it was not the identity of the actor but the presence of a bystander. Did it matter that the patient had the mistaken impression that the bystander was medical: see *Richardson* and compare with *Tabassum*. How should this question be approached morally and would the answer be different?

2.4 Is the legal regulation of consent consistent with the moral basis for consent? If not, are there any practical reasons or policy arguments why the basis for the legal duty should differ from the moral basis underlying consent?

2.4.2 Note that, ethically, it has been argued that the duty to disclose is greater in the research context that the therapeutic context? Why is this and is it justified? Consider the roles of autonomy and beneficence in consent. Relate this to the similar distinction between therapeutic and non-therapeutic treatment and the way the courts have denied that this should make any difference to the doctor's duty.

2.4.11 Consider the practical difficulties of such a requirement. Is the law's approach a reasonable compromise?

3.1.2 Consider the objective/subjective nature of the test. How competent does someone need to be to decide on a treatment proposed by the doctor? How can you test whether someone believes the information and how do you distinguish between believing the information and disagreeing about the implications? What is it that the patient needs to be competent to understand? How do you distinguish between incompetence and simply making a bad decision?

3.1.6 Does the judgment increase the vulnerability of women to being deemed incompetent simply because they are in labour? What are the implications in other situations such as the acutely ill person? Does pain automatically make you incompetent to make a treatment decision? How might the risk of unjustified paternalism be minimised?

3.1.7 Can the concept of 'broad terms' be affected by risk? Does risk make things harder to understand or is it simply that risk makes it more important to get it (both the question of competence and the actual decision) right? Should people be prevented from making the wrong decision when the risks are high?

3.3.3 This question is looking at how certain the individual has been in allowing for changes in circumstance and the clarity of information available to the healthcare worker. Has the woman allowed for the possibility of pregnancy within her directive? Is there any indication she has thought about it? Remember that the woman's autonomy outweighs the rights of the fetus. As far as part (b) is concerned remember that Lord Donaldson MR in *Re T* argued that if there is doubt then the presumption should be in favour of protecting life. Also, none of the State interests can outweigh an individual's autonomy providing it is clear what the individual wants. Think about factors that are relevant both internally (for example, change of mind, values, beliefs, etc) and externally (change of circumstances).

3.5.1 A declaration simply states whether the court considers a proposed action to be lawful or unlawful. This does not change its legal status but merely clarifies the position of the parties before they act.

3.5.2 If the medical treatment of incompetent patients is justified by the doctrine of necessity then it must be in their best interests. Can non-therapeutic research be in the patient's best interests? Is research that may also be therapeutic different?

4.1.4 Lord Donaldson MR's judgment effectively allows that minors may be competent to give consent but not competent to refuse consent in relation to the same decision. Consider this in relation to: autonomy as the basis for consent, understanding in broad terms, and the risk-related standard of competence.

4.2.5 Should consent be based on the same principle for children as for adults? In adults, the moral basis is often stated to be autonomy but are there any indications that beneficence may also play a role (consider the differential standard of information disclosure suggested for research. Also, the risk related standard). Is maturity gained from experience relevant or should autonomy be based solely on rationality as logic? Do children possess autonomy—is this relevant to the question? How is autonomy best respected—fostering present autonomy or protecting future autonomy?

4.5 The parties to consider will usually be the parents, the doctors and the court but the older child's view will also be important. Can you detect any bias in the way the court assesses the best interests (compare *Re T (A Minor) (Wardship: Medical Treatment*) with *Re C (A Child) (HIV Testing), Re B (A Minor) (Wardship: Medical Treatment)* and *Re J (A Minor) (Wardship: Medical Treatment)* (1990). Consider also *Re A (Children) (Conjoined Twins: Surgical Separation)*). If the court is unwilling to direct the doctors to treat, how does this affect the exercise?

5.1.1 See Glover (1977); Keown (1997). Distinguish sanctity of life (high value on life) from vitalism (absolute value on life). Is taking life ever justified and on what grounds (for example, self-defence)?

5.1.2 Think about moral personhood (self-awareness; potential for self-awareness; conferred moral value; intrinsic value) and compare with legal personhood. Should the fetus have a right not to be harmed without justification? What should count as justification? Should maternal rights outweigh fetal rights? Consider the situation where the woman risks dying unless her pregnancy is terminated. If the mother has chosen to become pregnant should

she have obligations towards the fetus, for example, not to deliberately do things that might harm the fetus (would you ban smoking, alcohol consumption, mountain climbing, crossing the road?).

5.1.5 Consider Art 3 and Art 8. Remember that Art 8 may be derogated from to protect the rights of others.

5.4 Consider the competing demands of respect for autonomy and beneficence. Consider the issue of overriding present autonomy to protect future autonomy (especially with children). Is paternalism ever justified?

6 If we act we potentially interfere with another's liberty to act. An omission, however, will not prevent someone else from acting. But, harm may be caused both by acting and failing to act. Is there a difference between harm caused by action and harm caused by inaction? When are we morally or legally responsible for failing to act? What factors generate a duty to act? See Glover (1977).

6.2.5 The distinction between an act and omission is only relevant if there is no duty to act.

6.2.7 See think point hint 3.5.1.

7.1.2 See *Curran v Bosze* (1990), in which the court refused to grant an order authorising blood tests to establish bone marrow compatibility. The potential donors were three and half year old twins who were half-siblings of the prospective recipient. The twins' mother, the former wife of the recipient's father, had refused consent. Calvo J stated: 'The evidence reveals three critical factors which are necessary to a determination that it will be in the best interests of the child to donate bone marrow to a sibling. First, the parent who consents on behalf of the child must be informed of the risks and benefits inherent in the bone marrow harvesting procedure to the child.

Secondly, there must be emotional support available to the child from the person or persons who take care of the child…

Thirdly, there must be an existing, close relationship between the donor and recipient. The evidence clearly shows that there is no physical benefit to a donor child. If there is any benefit…it will be

a psychological benefit…[This] is not simply one of personal, individual altruism…

The evidence establishes that it is the existing sibling relationship, as well as the potential for a continuing sibling relationship, which forms the context in which it may be determined that it will be in the best interests of the child to undergo a bone marrow harvesting procedure for a sibling.'

7.2.1 Consider, for example, commodification of the body and body parts; risk of monetary inducements on the poorest members of society; when does an inducement become coercive; and risk of black market.

7.3.1 Consider the impact of medical technology. Note that regulation of the vital bodily functions such as heart rate, breathing and waking/sleeping, are situated in the brainstem. Breathing can be taken over by a ventilator. Heart rate can also be artificially controlled by a pacemaker. Heart function can be augmented by drugs and medical devices such as a balloon pump.

7.3.2 See Maclean (1999). Consider the Race Relations Act, public policy and conditional gifts.

7.3.3 It contains elements of both types of system.

7.5.1 When an organ is removed at operation does the patient abandon that organ? Is property in a body part a morally reprehensible concept? Who invests in the body part in order to generate the profit? Do we have an investment in our body parts once they are outside our body—especially if they were diseased and threatening our existence?

8.1.2 Think about self-awareness, sentience, the intrinsic value of life, when life starts, the potential of the fetus to become self-aware, conferred moral value. Compare life as intrinsically valuable against moral personhood as valuable.

8.2.4 Consider the burden of imposing a duty on the mother, the role of insurance when allowing liability for negligent driving and the issue of litigation being divisive on the mother-child relationship. Is it logical or just to place the father under such a duty?

8.4 When does pregnancy begin: fertilisation or implantation? Is post-coital contraception a form of abortion? Note the government's acceptance of the morning after pill.

8.7.3 Does a disabled child bring any joy, pleasure or other benefit to the parents? If yes, then how is the court able to offset that benefit for disabled children but not for a healthy child?

9.1.2 Is the concept more malleable if given its everyday meaning? Does this protect the patient from, for example, political influences on the definition of mental illness? Are there any risks of using an everyday concept rather than criterion agreed by expert consensus?

9.2.4 In treatments such as psychotherapy, where patient cooperation is required, can the condition be treatable if the patient refuses to cooperate? Is prevention of deterioration a suitable benchmark for treatability? This may be a moot point because of the Government's proposals that would remove the treatability requirement. But, if there is no hope of treatment then can compulsory detention in a mental hospital be justified? Should the individual's detention be in prison on the basis of a criminal conviction rather than mental health criteria?

9.3.2 If someone has a mental illness that causes him to refuse food, are you treating his mental illness by force-feeding him or are you maintaining his physical health in order to buy time for the treatment of his mental disorder? Is the refusal of food a symptom of his mental illness? Note that treating symptoms may be the only option available to doctors, for example, where there is no cure. Is it logical to argue that symptomatic treatment is part and parcel of treating the illness? Consider pain relief. However, is it justified to equate the delivery of a baby with force-feeding? In *Re C,* were some of C's beliefs symptoms of his illness?

9.4.5 Does the doctrine of necessity require that the individual possesses a legally recognised right before it can be invoked? Consider the use of necessity to justify medical treatment of the incompetent.

9.5.1 Section 117 of the MHA 1983 creates a duty towards individuals while the duty created under the National Health Service Act 1977 is to provide services in general. Remember that the provision of services may be a condition of release from compulsory detention.

10.1.2 Consider both utilitarian and deontological arguments. Issues such as autonomy, trust and beneficence are important. Some commentators have suggested that personal information should be considered to be an extension of ourself—a gnomic equivalent to our body.

10.1.3 Think of ways of identifying people other than by name and address. A very rare disease, for example, will refer to a limited number of people, include that with the age and sex of the patient and identification may become possible.

10.1.5 Consider the protection of others from physical harm—how great a risk justifies disclosure, for example, consider the issue of doctor's HIV status: public health issues such as notifiable diseases, etc; the prevention of crime—any crime or only serious ones? (Remember the European principle of proportionality that should be applied under the HRA 1998); national security; the interests of justice, for example, court cases such as child custody (see *Re B (A Minor)* (1999)) or compensation claims; the prevention of suicide, for example, disclosing to the police that a prisoner may be high risk. Also think about the recipients of the disclosure. For example, is it justified to disclose a doctor's HIV status to a newspaper? Would it be justified to disclose his HIV status to his employers or his patients?

11.1.4 The court will be required to look more at the substance of the decision rather than just the procedure for making the decision. The court should also apply the proportionality test rather than the *Wednesbury* test of irrationality.

11.1.9 Consider factors such as need, merit, capacity to benefit, whether illness is self-inflicted, ability to pay, social status, and value of life. Which of these are justifiable? The issue is one of distributive justice.

11.3.1 Patients suffering from uncontrollable pain especially where life expectancy is very short and they have little opportunity

for achieving any goals that they consider worthwhile. Do patients in PVS have interests? Is 'life' an interest even in the absence of awareness? If a patient has no interests can it be in their best interests to die? (Is that even the right question to be asked in this situation?)

11.3.2 Would it be degrading to an unconscious person to use him as an ashtray? Is the unconscious patient the 'victim' of degrading treatment or is it the community that suffers because it breaches common humanity?

11.3.6 Article 9 means that the individual's beliefs should be respected even where they are not part of a recognised religion. Is this compatible with existing English law: see *St Georges Healthcare NHS Trust v S* (1998)?

12.1.6 Think about the relevance of Art 8. However, be aware of Dame Butler-Sloss P's comments (in a different context) in *NHS Trust A v Mrs M; NHS Trust B v Mrs H* (2000): 'I rather doubt that the families have rights under Art 8 separate from the rights of the patient.' Note that *Powell* involved an omission rather than an action and the court argued that the doctor had no duty to act (candid disclosure). What if the doctor had negligently disclosed an untruth that caused the relatives psychiatric damage?

12.3.1 The ambulance need only be concerned with the sick individual; there is no risk to other members of society. A fire may spread from the affected person's property and damage other property and thus, the fire service's duty is not limited to a single identifiable individual but may incur much greater liability. Is this type of argument sustainable in all circumstances?

12.4.5 It may depend on the circumstances. If the junior doctor is stepping in because the senior doctor is ill and the situation is an emergency, then he may be judged against the standard expected of a junior doctor under such circumstances. However, if he has been appointed as a locum to cover holiday leave, then he would be judged against the standard expected of any doctor occupying that post even if he has not received the equivalent training or had a similar level of experience.

12.5.4 In *McGhee,* the cause of the dermatitis was known—the brick dust. A failure to provide washing facilities increased the risk that the brick dust would be damaging. In *Wilsher,* the cause was unknown so the plaintiff could not argue that the oxygen treatment had increased the risk of the causal factor causing damage.

13.2.5 Consider which factors are relevant to balancing the various interests in encouraging the development of new drugs and equipment against those relevant to the protection of individuals injured by those new products. The danger is that too great a liability will discourage innovation and research, and it is in the public interest to improve the drugs and treatments available. However, it is not just if all the risks should fall on the victim. The State needs to find a way to distribute those risks fairly. Does s 4(1)(e), within the context of the Act as a whole, achieve that balance?

14.3.1 Depends on the doctor's motive. If it is to relieve pain, suffering or distress then the doctrine of double effect will apply.

15 The doctrine of proportionality will apply: a legitimate aim; necessary in a democratic State; and the minimal infringement required to achieve that aim.

16.1.1 What are the advantages of self-regulation: for example, first hand experience may be useful, expert knowledge (consider the court's reluctance over the *Bolam* test), vested interest in maintaining the profession's reputation. Disadvantages include: for example, closed ranks mentality, lack of objectivity, difficulty in disciplining a colleague, values skewed by medical training and experience may result in undue sympathy for the health professional over the patient.

16.3.4 Think about the effect of the power imbalance between the health professional and the patient. Also consider the issue of transference (the patient's feelings of gratitude are transferred out of the context of the professional relationship and are attached to the professional as an individual. This may result from the patient misinterpreting

professional concern for personal concern and interests). The professional relationship is one of trust—does the professional abuse that trust if they use the opportunity for developing a relationship? Does it make any difference if the patient was already in a pre-existing relationship or not? Does the genuineness of the doctor's feelings matter?

Useful Internet Links

Note: all sites listed start http://www except *** which are just http://

Internet sites related to law

open.gov.uk/lcd/lcdhome.htm	The Lord Chancellor's Department: information about new and pending legislation
courtservice.gov.uk	Transcripts of court judgments
lawreports.co.uk	Weekly Law Reports web site: includes summaries of recent judgments
bailii.org	British and Irish Legal Information Institute
austlii.edu.au	Australian Legal Information Institute
hcourt.gov.au	Judgments from the High Court of Australia
lexum.umontreal.ca/csc-scc	Judgments from the Supreme Court of Canada
echr.coe.int	Information and judgments on the European Convention of Human Rights
***europa.eu.int/eur-lex/en/index.html	EU Legal information
***europa.eu.int/cj/en/index.htm	European Court of Justice

	judgments
markwalton.net/index.html	Mental health law website with links to many other sites
parliament.thestationery-office.co.uk	Includes House of Lords and House of Commons publications
open.gov.uk	Government information and some publications
hmso.gov.uk	Her Majesty's Stationery Office; includes Acts of Parliament on line
ukcle.ac.uk	UK Centre for Legal Education
law.cam.ac.uk/jurist/index.htm	Jurist—the legal education network; resources; links; jobs
***webjcli.ncl.ac.uk	Web Journal of Current Legal Issues: peer reviewed journal. Full text on-line. All areas of law
solent.ac.uk/law/mjls/default.htm	Mountbatten Journal of Legal Studies; All areas of law, peer reviewed, full text on-line.
murdoch.edu.au/elaw	Murdoch University (Australia) on-line law journal. All areas of law
***www3.oup.co.uk/medlaw	On-line index and abstracts for the Medical Law Review

Internet sites related to Healthcare

bmj.com	Full access to the British Medical Journal on-line
ncbi.nlm.nih.gov/entrez/query.fcgi	Free access to Pubmed from the U.S National Library of Medicine. This is a comprehensive database of references (and many abstracts) of all medical and related

	publications
who.org	The World Health Organisation: articles and fact sheets
gmc-uk.org	The General Medical Council: free guidance available to download. Also information about pending hearings
ukcc.org.uk	The United Kingdom Central Council (Nursing professional body)
doh.gov.uk	Department of Health website

Internet sites on bioethics

nih.gov/sigs/bioethics	Links to many resources
med.upenn.edu/~bioethic/index.shtml	Bioethics articles, information and links

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Index