CONSENT

Contents

Medical Examination in Custody

C G M Fernie, University of Glasgow, Glasgow, UK

Introduction

Modern-day thinking in medical ethics is that consent should be valid or real. Consent may be explicit or implied, it may be verbal or written, but in the competent adult it should be informed and, certainly, be provided without coercion. Consent is not an endpoint but rather a continuing process based on the mutual respect normally found in the doctor–patient relationship. However, there are circumstances in which a doctor has to work professionally, such as those usually encountered by the forensic physicians (police surgeon), where there is no opportunity to develop this relationship in the traditional manner. Although consent in theory has been provided by the detainee, some may consider this to have been obtained under a degree of duress because of the circumstances in which that consultation takes place. Also, there are a number of situations encountered by the forensic physician, such as those within the provisions of the Road Traffic Act 1988, where, although there may be an apparent freedom of choice, a refusal to participate in the process will constitute an offense (failing sound medical reasons for so doing) if that person does not agree to the proposed examination.

Accountability

The medical profession is becoming increasingly accountable and there are a number of routes through which a forensic physician may have to respond if he/she fails to obtain adequate consent. Principally, these will be alleged medical negligence if the information imparted is not in keeping with the professional standard in place at the time in question, but it is possible that a charge of criminal assault may be faced by that doctor and, should that charge be proven, there will be an automatic referral to the General Medical Council (GMC) for consideration as to whether this constitutes serious professional misconduct. Indeed, a number of complainants are based on that doctor's national regulatory body as a "first stop" when they are dissatisfied as to the way in which a doctor has behaved.

The GMC makes it clear that successful relationships between doctors and patients depend on trust. To establish that trust one must respect patients' autonomy – their right to decide whether or not to undergo any medical intervention even where a refusal to do so would result in harm to that individual or his/her own death. Autonomy is one of the *prima facie* moral principles espoused by Gillon and is surely one of the cornerstones of modern ethical medical practice. Of course, this applies even in the custodial setting.

The GMC specifically recognizes that a doctor must take particular care in order to ensure voluntary decision-making and has identified that persons detained by the police may be particularly vulnerable in this respect. They emphasize that where such patients have a right to decline treatment, the doctor involved has a duty to do his/her best to make them aware of this option and that they are able to exercise this right.

Development of Consent

It is now almost taken for granted in medical practice that before embarking upon a consultation the doctor involved should ask that patient for his/her consent. Some may argue that the interchange between doctor and patient in the custodial setting is not necessarily a consultation in the true sense of the word but because the purposes of that meeting are often not known when it commences, the ethical issues are the ones that cannot be abrogated simply because that doctor is the agent of a third party. Also, different criteria apply in respect to capable and incapable persons and this matter is of particular relevance in the work performed by the forensic physician where over half may be under the influence of illicit substances and a third affected by alcohol.

As long ago as the beginning of the twentieth century, the great American Jurist Cardozo summed up the principle of consent as follows:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.

Despite this prescient analysis, it was only in the last five years that the GMC recognized the importance of consent being informed, which is a concept initially developed in other jurisdictions within cases such as *Canterbury* v. *Spence* ((1972) (464 F. 2d 772, 780)), where it was held that, although the information imparted by the doctor seeking consent had reached that required to meet the Bolam test it was deemed insufficient by the court.

The GMC does recognize that in an emergency where consent cannot be obtained, one may provide medical treatment to anyone who requires this, provided the treatment is limited to what is immediately necessary to save life or to avoid significant deterioration in that patient's health. This principle applies as much in the clinical forensic setting as in other areas of medical practice. This approach is underwritten by case law and in the Canadian case of *Mulloy* v. *Hopsang* ((1935) 1 WWR 714). It was made clear by this patient that a doctor should not amputate his hand under any circumstances as he wished to consult his own specialist. However, once anesthesia had been administered and an adequate examination undertaken for the hand that had previously been wrapped up, the doctor formed the view that amputation was required and went ahead. When the patient sued in battery, it was held that this management was not justified in the circumstances in that case.

Also, forensic physicians are required to respect the terms of any valid advance refusal which they know about, or that is drawn to their attention. In *Malette* v. *Shulman* ((1988) 63 OR (2d) 243 (Ontario High Court)), the young woman who had been brought into the emergency department whilst unconscious had a card indicating she was a Jehovah's Witness and that she would not consent to a blood transfusion even if that were to the danger of her life. The Court held in favor of the plaintiff, as there really should have been no doubts as to the position.

In the introduction to *Seeking Patients' Consent: The Ethical Considerations,* the GMC stipulates that a doctor is required to respect patients' autonomy, including their right to decide whether or not to undergo any medical intervention even where a refusal may result in harm to themselves or in their own death. Further, this right is protected in law and a registered medical practitioner is expected to be aware of the legal principle set by relevant case law in this area (advice can be obtained from medical defense bodies such as the Medical Defence Union, Medical Protection Society, the Medical and Dental Defence Union of Scotland, or professional associations such as the British Medical Association (BMA), or one's employing organization). Existing case law gives a guide as to what can be considered the minimum requirements of good practice in seeking informed consent from patients.

Although a doctor wishing to visualize the tonsillar area of a patient can presume implied consent should that person open his/her mouth to receive a spatula, it would be rare in the context of clinical forensic medicine that explicit consent would not be obtained through provision of a history, undertaking an examination, and producing a report for the purpose of the court. One of the leading cases in regard to implied consent is that of *O'Brian* v. *Cunard SS Co.* ((1891) 28 N E 266 (Sup. Jud. CT. Massachusetts)), where an immigrant to the USA proffered her arm for smallpox vaccination. However, a comparable type of situation for the forensic physician would be an inebriated individual holding out his/her arm for venous blood sampling under Section 5 of the Road Traffic Act 1988, where that person has been arrested for an alleged drink-driving offense. Whilst the individual's capacity must be in doubt in this situation, it is in the public interest that a sample is obtained and, indeed, with the Police Reform Act 2002 coming into force, it is recognized that where there is an unconscious drunk, in certain specified circumstances it is lawful to obtain a sample from him/her without consent at the time although permission subsequently has to be granted should he/she later recover, albeit a refusal will constitute an offense.

Normally, oral consent is equally valid to written consent (especially where witnessed), but the GMC recommends that written consent should be obtained in cases where providing clinical care is not the primary purpose of the investigation or examination and there may be significant consequences for the patient's employment, social, or personal life. This guidance is of particular relevance in the area in which the forensic physician functions.

This regulatory body reminds doctors that they should use the patient's case notes and/or a consent form in order to detail the key elements of any discussion that takes place with the patient, including the nature of information provided, specific requests by the patient, and details of the scope of the consent given. It may be that the habitual introduction that a forensic medical examiner uses and an explanation as to the use of a report for court purposes would suffice.

Analysis of Informed Consent

In regard to the concept of informed consent, there are three pertinent issues that the forensic physician should consider in deciding upon the adequacy of this:

1. Did that person have capacity in the eyes of the law? In other words, was the patient competent to give consent? The forensic physician may be asked to examine individuals whose age span ranges from newborn to elderly and there will be potential conflict of interest between parent and child or elderly people and their caretakers. Even if adequate information was imparted, did a person under the (significant) influence of alcohol or drugs understand the likely implications that would flow from this decision?
2. Was the individual concerned given appropriate information beforehand – in other words, was the consent truly informed?
3. Was the consent given voluntarily? Voluntariness is probably the most significant ethical worry that the forensic physician is likely to confront, particularly when examining an individual for fitness to be detained or fitness to be interviewed, both categories of which make up the main workload in this subspecialty.

Capacity

The first issue here is, of course, a particular problem given the number of individuals (Figure 1) who are affected by either drugs or alcohol in the typical workload of the forensic physician in the UK (Table 1).

It is worth noting in respect to alcohol that estimations of the effects of drink are notoriously unreliable under a blood alcohol concentration of 200 mg/100 ml of blood. Whether an individual is significantly impaired from a substance may be even more contentious, and there has been considerable debate as to the appropriateness of the standardized field sobriety testing used in the USA and whether such tests have been truly validated for the purpose for which they are being used in the context of the Road Traffic Act. Given the number of detainees that are under the influence of either alcohol or a substance and that the degree of intoxication may well be underestimated, it seems reasonable to question how legitimate any consent given might be. Considerable work has been undertaken on fitness of the person to be interviewed as a result of concerns such as these and also whether that individual may be suffering from a mental disorder that would affect his/her capacity.

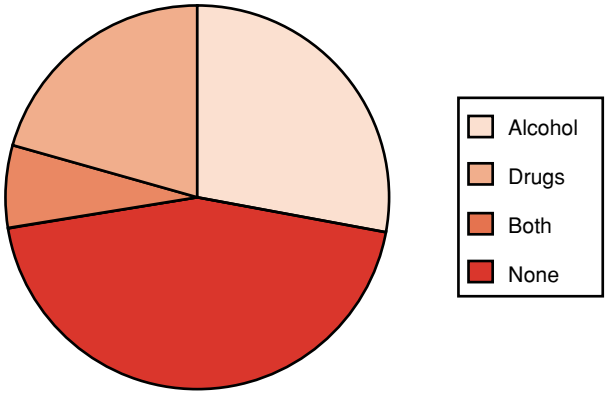

Figure 1 Typical proportions of individuals affected by drugs and/or alcohol.

Table 1 A year in the life of an urban forensic physician

Persons in custody	468
Sudden death	81
Mental health	39
Child sexual abuse	21
Examination of injuries	18
S4 Road Traffic Act 1988	14
S5 Road Traffic Act 1988	13
Serious assault	13
Rape	13
Nonaccidental injury	10
Murder	11

The Codes of Practice to the Police and Criminal Evidence (*pace*) Act 1984 state that: "No person, who was unfit through drink or drugs to the extent that he is unable to appreciate the significance of questions put to him in his answers, may be questioned about an alleged offense in that condition."

The Codes of Practice clarify that "The Police Surgeon can give advice about whether or not a person is fit to be interviewed."

Under Scots Law, this issue is even more problematic in that there is not a statutory equivalent to the Police and Criminal Evidence Act 1984 and much is left to the Force Standing Orders, where, although in practice similar decisions may be taken, it is noticeable that there are considerably fewer cases where there is a requirement to determine fitness to be interviewed as opposed to that found in England and Wales.

Information Imparted

The second point is a matter that varies between individual practitioners and within the joint guidance issued by the Association of Forensic Physicians and the British Medical Association in 1996. This recommends that police surgeons should state explicitly: "Before any information is volunteered, part of their role is to collect any evidence for the prosecution."

The emphasis here is very much on the word "before" as the interim guidelines are prefaced by a note on the legal position in which the view is expressed that the Crown Prosecution Service (CPS) has argued that police surgeons are part of the prosecution team and are therefore obliged to disclose all information to enable the CPS to assess whether it is "material" to their case or not. In contrast, legal advice taken by the Medical Defence Union appears to contradict this belief in that their opinion suggests that police surgeons are only part of the investigating team insofar as they are required to undertake forensic tasks. The ethical dilemma here is that of the dual role where, if the forensic physician is acting as a medical adviser to the victim or suspect, the fact that he/she is supplied by the police does not make him/her their representative. The conclusion is that any information that a doctor obtains in this context is within the ordinary capacity of a medical practitioner and the usual duty of confidentiality will apply. Although this article was classified as being an interim guideline, it is uncertain what its status is until new legislation is passed or it is superseded by case law. However, as a consequence of this document, it seems reasonable to presume that any information volunteered might be used as evidence in the case and that no assurances can be given that confidentiality will be maintained. Thus, in obtaining consent to the examination and provision of a report, forensic physicians should ensure that the person has understood and agreed to this potential lack of confidentiality before any information is collected or an examination undertaken.

Probably the most important aspect to consider in relation to consent and the forensic medical examiner, at least in legal terms, is the issue of whether the consent has been suitably informed. Here, guidance must be sought from case law on the subject generally as the Association of Police Surgeons and the BMA interim guidelines appreciated that specific clarification was not yet available. For the law to accept the validity of the consent obtained, the patient must first have been supplied with adequate information in order to achieve "informed consent." The seminal case in this respect was that of Sidaway in 1985, which gave legal guidance on the doctor's duty to inform the patient on what he or she was proposing (*Sidaway* v. *Board of Governors of the Bethlem Royal and the Maudsley Hospital* ((1984) 2 WLR 778; (1985) AC 871; (1985) AC 871 at 900, [1985] 1 All ER 643 at 663, HL; (1985) AC 871 at 903, [1985] 1 All ER 643 at 665; (1985) 2 WLR at 493)). However, before examining the significance of this case it is worthwhile considering the background that led to it. It seems reasonable to take as a starting point the cases of *Hunter* v. *Hanley* (1955 SC 200, 1955 SLT 213) and *Bolam* v. *Friern Hospital Management Committee* (1957; 2 ALL ER118, [1957] 1 WLR 582), which provide the definition of medical negligence in the UK. It has already been suggested that, although a court may not hold that an action against a forensic medical examiner should be taken in negligence rather than battery, it would seem that its normal reluctance to do so might prevail in this situation.

In the Australian case of *Rogers* v. *Whitaker* ((1992) 109 ALR 625 at 633, [1993] 4 Med LR 79 at 83), concerning a case of sympathetic ophthalmia, the view was expressed that consent is relevant to actions framed in battery or trespass, not in negligence, which is simply a matter of standards. If one does accept that a case against a police surgeon would not be in battery unless the circumstances were exceptional, and an argument has already been put forward that the normal basic rules regarding a traditional medical consultation should apply, then the cases relating to this situation should be those one would usually consider in relation to consent to the examination.

There seems little contention that the position in these cases has, thankfully, moved on from *Hatcher* v. *Black* in 1954 where Lord Denning appeared to endorse a "therapeutic lie."

Thus, British courts continued with the application of the professional standard even though the concept of the "prudent patient" test was adopted in 1972 in *Canterbury* v. *Spence* in an American court. It was said here for the first time that doctors must disclose to their patients any material risk inherent in a proposed line of treatment. By 1980 *Reibl* v. *Hughes* ((1980) 114 DLR (3d) 1) found the Canadian Supreme Court also rejecting the "professional medical standard" in determining how much a doctor must disclose to a patient. Although the court accepted that a particular patient might waive the right to know, voluntarily grasping "the doctor knows best" doctrine, this is unlikely to be applicable to virtually any of the situations encountered by the forensic medical examiner.

However, in the UK there was evolution in *Chatterton* v. *Gerson* ((1981) 3 WLR 1003) where the issue of how much information the doctor should be required to give the patient was once more brought before the courts. It was alleged that, although Dr. Gerson was in no way negligent in his conduct of the surgery, he failed to give his patient sufficient information for her "informed consent." However, Mr. Justice Bristow took the view that, once a patient has been informed "in broad terms of the nature of the procedure which is intended," the consent is real and no action for battery will lie. The contentious issue here is what he meant by

his phrase "in broad terms." He clarified this by stating that an action in battery would lie only if a wholly different procedure from the one agreed to was carried out or if the patient's agreement was obtained through fraud. This would very likely be true with the forensic medical examiner, although it is unlikely that a broad consent would suffice if the results of the examination might result in the person incriminating him/herself. The obvious pertinent question is whether there is a difference between therapeutic and nontherapeutic treatments? Mrs. Potts, who won £3000 damages in 1983 after an injection of Depo-Provera, appears to suggest that there is a difference, although this was certainly an emotive controversy at the time.

In Sidaway, the House of Lords did explore at length the doctor's duty to inform patients due to the need for clear legal guidance. There was, however, a three-way division, with only Lord Scarman opting for what was a radical shift at that time, giving consideration to the concept of informed consent. Lord Diplock adopted a decidedly conservative view with the status quo of the Bolam test. Lord Bridge, with whom Lord Keith concurred, and Lord Templeman were more pragmatic in their speeches, taking a middle course. Lord Bridge held that: "A judge might, in certain circumstances, come to the conclusion that the 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 could fail to make it." Lord Templeman took the view that "the court must decide whether the information afforded to the patient was sufficient to alert the patient to the possibility of serious harm of the kind in fact suffered." Although Lord Scarman also found against Mrs. Sidaway, he did deliver a dissenting judgment when he rejected current medical practice as the test of what the patient needs to be told. His powerful judgment asserted the patient's right to know. The patient's right to an autonomous decision was the factor to which Lord Scarman made the issue of advice given to the patient distinct from other aspects of medical care. The doctor should be liable "where the risk is such that in the court's view a prudent person in the patient's situation would have regarded it as significant." Despite this, Lord Scarman did still feel that the doctor should to some extent be protected by a defense of "therapeutic privilege." This would permit a doctor to withhold information if it can be shown that "a reasonable medical assessment of the patient would have indicated to the doctor that disclosure would have posed a serious threat of psychological detriment to the patient."

Thus, it can be seen from the way that case law developed and affected GMC guidance, the principles considered within Sidaway did subsequently alter the way in which doctors impart information to patients within the UK although, in any event, the Bolam approach was later modified in Bolitho when a court had to deliberate upon competing expert evidence.

Voluntariness

Finally, voluntariness is a contentious issue, and with the Human Rights Act 1998 coming into force there must be particular concern as to whether there is a breach of Article 6, the right to a fair hearing, especially with the increasing likelihood of forensic physicians being regarded as employees with the consequent erosion of independence that was once considered an integral part of this practice. Also, Article 8, the right to respect for one's private and family life, is another principle that may be breached in these circumstances where in reality there is not a true choice of medical practitioner.

Another aspect of consent that has benefited from relevant case law in Gillick and statute (*Gillick* v. *West Norfolk and Wisbech AHA* (1985) 3 All ER 402), at least in Scotland by way of the Age of Legal Capacity Scotland Act 1991, is that of capacity in regard to the mature minor whom the forensic physician regularly encounters as a suspect in a criminal act. Of course, it is necessary to distinguish between the ability to consent to certain medical treatments that will benefit that individual and an assessment for forensic purposes that may have consequences for their future liberty and here, should there be doubt, the court may determine that any evidence thus obtained is inadmissible.

Conclusion

In conclusion, it is no longer appropriate in the twenty-first century merely to pay lip service to the concept of consent and a failure to comply with this important principle may not only result in civil litigation against a doctor who has fallen below the necessary level by way of a failure to inform the patient adequately, but also, at least theoretically, to face criminal charges of an assault upon that individual's person. Further, with the exponential rise in GMC cases that has become apparent to all medical defense organizations, the reality is that a breach of the GMC's guidance may constitute serious professional misconduct with ramifications including erasure from the Medical Register as a consequence. Where a forensic physician comes into the category of having dual obligations, the possibility of having to account for his/her actions is a practical consideration that should not be underestimated.

See Also

Consent: Treatment Without Consent; Confidentiality and Disclosure

Further Reading

Association of Police Surgeons and British Medical Association (1996) *Interim Guidelines and Confidentiality for Police Surgeons*. London: The British Medical Association.

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Treatment Without Consent

C G M Fernie, University of Glasgow, Glasgow, UK

Introduction

Although it is quite clear that consent should be informed and there is both case law and guidance from the General Medical Council (GMC) to support this interpretation, there may yet be circumstances when a doctor, particularly a forensic physician, is placed in a position where he/she has to contemplate treating a patient without consent.

Consideration has already been given to circumstances in which a patient may lack capacity by way of age. Both statute in Scotland and case law in England and Wales by way of the Gillick case (*Gillick* v. *West Norfolk and Wisbech AHA* [1986] AC 112) have assisted considerably in dealing with situations that previously may have caused difficulty because the individual concerned was a minor and so was not legally able to consent.

Capacity

What is more problematic is when a patient is not in a position, whether through short- or long-term incapacity, to indicate agreement to a doctor providing a proposed treatment.

Traditionally, the courts have been charitable to the medical profession in as much as they appear to take the view that medical practitioners recognize comprehending patients. This was the position until 1993 when developing case law formalized the way in which such matters should be considered.

Lord Donaldson's judgment in Re T ((An Adult) (Consent to Medical Treatment) [1993] Fam 95, [1992] 2 FLR 458) concludes with a helpful summary of how to deal with the issue of capacity. The propositions contained in the first four numbered paragraphs govern this case. Those propositions are:

1. Prima facie, every adult has the right and capacity to decide whether or not he/she will accept medical treatment, even if a refusal may risk permanent injury to his/her health or even lead to premature death. Furthermore, it matters not whether the reasons for the refusal were rational or irrational, unknown or even nonexistent. This is so, notwithstanding the very strong public interest in preserving the life and health of all citizens. However, the presumption of capacity to decide, which stems from the fact that the patient is an adult, is rebuttable.
2. An adult patient may be deprived of his/her capacity to decide by long-term mental incapacity.
3. If an adult patient did not have the capacity to decide at the time of the purported refusal and still does not have that capacity, it is the duty of the doctors to treat him/her in whatever way they consider, in the exercise of their clinical judgment, to be in his/her best interests.
4. Doctors faced with a refusal of consent have to give very careful and detailed consideration to what was the patient's capacity to decide at the time when the decision was made. It may not be a case of capacity or no capacity; it may be a case of reduced capacity. What matters is whether at that time the patient's capacity was reduced below the level needed in the case of a refusal of that importance, for refusals can vary in importance. Some may involve a risk to life or of irreparable damage to health and others may not. Those propositions are common ground. It is also common ground that a refusal can take the form of a declaration of intention never to consent in the future or never to consent in some future circumstances, to borrow the words of Lord Donaldson in Re T. That proposition has been confirmed by the judgments and speeches in Bland's case (*Airedale NHS Trust* v. *Bland* [1993] 1 FLR 1026).

Later in 1993, the court evolved a more rigorous three-stage test in assessing a patient's capacity and this was enunciated by Thorpe J in Re C ([1994] 1 All ER 819), when he took the view that the patient must be able to:

- comprehend and retain the relevant information
- believe it
- weigh it in the balance so as to arrive at a choice.

Whilst some patients may permanently lack capacity due to a mental disorder or retardation, others who are normally quite capable of making decisions about their healthcare may be temporarily deprived of it by conditions such as intoxication with drugs or alcohol, unconsciousness, confusion, pains, or, indeed, a phobia of medical treatment.

Comment has already been made that, in order to be valid, the consent provided must be voluntarily given subsequent to the doctor having imparted the relevant information to either that person or whoever has parental responsibility when the individual concerned is a minor.

Autonomy

The importance of autonomy as a concept should not be minimized. One side of the coin is an ability to consent to a proposal in someone who has the requisite capacity, while the other side is refusal of treatment.

Negligence

Although most cases involving treatment without consent will be dealt with through the tort of negligence, an alternative in this situation, albeit it is now out of fashion, would be the tort of battery, which is a type of trespass of the person.

Specific reference to this issue was made in *Chatterton* v. *Gerson* ([1981] QB 432) where it was not thought to be an appropriate way to deal with alleged negligent disclosure of information by doctors provided they had acted in good faith and in the best interests of those concerned.

As Mr Justice Bristow put it in *Chatterton* v. *Gerson*, once a patient has been informed "in broad terms of the nature of the procedure which is intended," the consent is real and no action for battery will lie.

Of course, this begs the question of what constitutes being informed "in broad terms" and this query was addressed when he held that an action in battery would lie only if a wholly different procedure from the one agreed to was carried out or, alternatively, if the patient's agreement was obtained through fraud.

The General Medical Council

In the GMC's publication *Seeking Patients' Consent: The Ethical Considerations*, it specifies that a doctor must not exceed the scope of the authority given by a patient, except in an emergency. Thus, the medical practitioner providing treatment or undertaking an investigation should give the patient a clear explanation of the scope of consent being sought.

This principle applies particularly where:

- Treatment will be provided in stages with the possibility of later adjustments.
- Different doctors (or other healthcare workers) provide particular elements of an investigation or treatment (for example, anesthesia in surgery).
- A number of different investigations or treatments are involved.
- Uncertainty about the diagnosis, or about the appropriate range of options for treatment, may only be resolved in the light of findings once an investigation or treatment is underway, or during the course of treatment, and when the patient may be unable to participate in decision-making.

In cases of this type, it is necessary for the doctor to explain how decisions would be made about whether or when to move from one stage or one form of treatment to another. It is important that there is clear agreement as to whether the patient consents to all or, alternatively, only parts of the proposed plan of investigation or treatment, and whether further consent will have to be sought at a later stage.

Further, the GMC stipulates that, if the patient is unconscious, and if the doctor decides to treat a condition that falls outside the scope of the original consent, that doctor has to consider that he/she may be challenged in the courts, or subject to a complaint to the regulatory body. Consequently, the GMC recommends that the doctor concerned should seek the views of an experienced colleague, if possible, before providing that treatment, and be prepared to justify the decision to go ahead.

An important point is that the patient should be informed what the doctor has done and why, as soon as the patient is sufficiently recovered to be able to comprehend this.

In its guidance contained within *Good Medical Practice*, the GMC makes it clear that in an emergency, a doctor "must offer anyone at risk the treatment you could reasonably be expected to provide."

Doctrine of Necessity

This approach is again backed up by case law in Re F ([1990] 2 AC 1), where Lord Brandon observed:

> In many cases, however, it will not only be lawful for doctors, on the ground of necessity, to operate on or give other medical treatment to adult patients disabled from giving their consent; it will also be their common law

> duty to do so. In the case of adult patients made unconscious by an accident or otherwise, they will normally be received into the casualty department of a hospital, which thereby undertakes the care of them. It will then be the duty of the doctors at that hospital to use their best endeavours to do, by way of either an operation or other treatment, that which is in the best interests of such patients.

Having made this point, in their advice on consent, the GMC also advises that, in an emergency, where consent cannot be obtained, you may provide medical treatment to anyone who needs it, provided the treatment is limited to what is immediately necessary to save life or avoid significant deterioration in the patient's health.

It seems that here the emphasis is very much on limiting the treatment to what is required for preservation of life or to avoid a significant deterioration.

The proviso is that, if there is known to be a valid advance directive that the doctor knows about, or that is drawn to the attention of the doctor, the doctor is required to respect this.

This general proposition is supported in case law and if a patient has indicated in advance that he/she has anticipated the examination or treatment and refused that treatment, then the doctor cannot justify proceeding in that situation. This accords with the principle that the wishes of the competent adult patient should be respected.

In the Canadian case of *Malette* v. *Shulman* (1988) 63 OR (2d) 243 (Ontario High Court), a young woman was brought unconscious into the Accident and Emergency department. Despite having a card which clearly stated that she was a Jehovah's Witness and would not agree to a blood transfusion under any circumstances, even if her life were in danger, the doctor proceeded to administer blood. The court held that the doctor had committed a battery. There was no room for doubt and the patient concerned had gone to some trouble to ensure that no doctor should be in doubt of her refusal of blood in any contingency. The argument that this refusal could not be "informed" due to the significant change in her circumstances was rejected by the court. In cases of this type, it is important that necessary treatments are distinguished from those that are merely convenient for the medical staff. In general, it is fairly safe to say that treatment provided while a patient is temporarily incompetent should involve the minimum necessary for health, whereas any treatment that can reasonably be postponed until competence is regained should be deferred.

Despite this, the more recent comparable British case of Re T ((adult)(refusal of medical treatment) [1992] 4 All ER 649, (1992) 9 BMLR 46, CA) appears to have come to a different conclusion in a not dissimilar scenario. This case involved an adult pregnant Jehovah's Witness in a road traffic accident who signed a form of refusal for a blood transfusion. Subsequently, her condition deteriorated following a cesarean section and the birth of a stillborn baby, and a court order was obtained legalizing a blood transfusion on the grounds that it was manifestly in her best interests. The Court of Appeals, surprisingly, upheld this declaration. This was a fundamental decision by an adult patient with no known mental incapacity who chose to exercise her right to consent or refuse to a proposed treatment. Why was it that the court appeared to authorize involuntary treatment? Effectively, they changed involuntary into nonvoluntary and argued that T's mental state had changed to such an extent that she could not make a valid choice between transfusion and death. The theory was that, if there was doubt as to how the patient was exercising her right of self-determination, that doubt should be resolved in favor of the preservation of life. This was, however, qualified by Lord Justice Staughton who said: "I cannot find authority that the decision of a doctor as to the existence or refusal of consent is sufficient protection, if the law subsequently decides otherwise. So the medical profession . . . must bear the responsibility unless it is possible to obtain a decision from the courts."

Other jurisdictions have considered the question of going beyond the stated wishes of the patient with adverse consequences for the doctor in cases such as: (1) *Marshall* v. *Curry* ([1933] 3 DLR 260) (consent was given to an operation to cure a hernia; the doctor removed the patient's testicle; action in battery); (2) *Murray* v. *McMurchy* ([1949] 2 DLR 442) (consent was given to a cesarean operation; the doctor went on and sterilized the patient; the doctor was liable for trespass to the person); and (3) *Mulloy* v. *Hop Sang* (Supreme Court of Manitoba, Appellate Division, 1934. [1935] I WWR 714) (the doctor was told to repair the hand and not to amputate; the doctor performed an amputation, and was held liable in trespass).

Once more, the point is made that the patient should be informed as soon as possible once he/she has sufficiently recovered to understand what has taken place.

Incapacity

With the exceptions of someone fulfilling the criteria within the Adults with Incapacity (Scotland) Act 2000, no one is permitted to consent on behalf of incompetent adults, but it is clearly necessary that those persons are not denied beneficial treatment.

The incompetence may be short-term, for example from anesthesia, sedative drugs, intoxication, or transient loss of consciousness, and in this situation one should consider case law and not just the GMC guidelines previously set out.

Clearly, it is necessary to distinguish between treatments that are essential and those that are simply convenient where the usual approach is that the minimum necessary treatment to preserve well-being is given and any more definitive procedure is deferred until that patient once again achieves competence.

Until the enlightened piece of Scottish legislation alluded to came into force there was major difficulty for those within the caring profession in respect to treatment of patients who are incapaxes, that is, those who are incompetent and are not in a position to give consent to medical treatment even if that is in their own best interests.

It has already been pointed out that the doctrine of necessity provides protection to that care that is required to preserve life but no further, and the dilemma exists in such cases as those with mental disorders who are unable to consent to relatively minor conditions such as dental extractions that would obviously be beneficial but which do not fall into the category of being an emergency.

Unfortunately, the Act alluded to applies only to the Scottish jurisdiction and, thus far, has not been extended to the remainder of the UK. The purpose of this legislation is to provide ways to manage the financial and welfare affairs of people who are unable to manage them for themselves.

The Act provides various methods of intervening (i.e., taking decisions or action) on behalf of an adult. Interventions can cover property and financial affairs, or personal welfare matters, including healthcare. When deciding whether to intervene the statute stipulates that the following principles should be applied:

- The intervention must be necessary and must benefit the adult.
- The intervention must be the minimum necessary to achieve the purpose.
- Account must be taken of the adult's present and past wishes and feelings (and every possible means of communicating with the adult should be taken to find out what these are).
- The views of the adult's nearest relative and primary carer, and of any other person with powers to intervene in the adult's affairs or personal welfare, or with an interest in the adult must be taken into account, so far as it is reasonable and practicable to do so.
- Any skills he/she has must be encouraged.

Consideration should be given whether it would be possible to intervene without using the Act.

Detailed codes of practice have been incorporated into the legislation both in respect to financial management and, innovatively, a welfare power of attorney who must be registered with the Public Guardian.

However, in England and Wales the dilemma still exists in that where a mentally incapacitated individual cannot authorize his/her own treatment, no one else legally has the authority to so do.

Of course, treatment for a mental disorder falls under the Mental Health Act 1983 (there is a Scottish equivalent currently being revised) but this only allows psychiatric treatment as opposed to treatment for unrelated physical illnesses to which that individual is unwilling to agree, even if patently it is in his/her best interests.

In Re F ([1990] 2 AC 1) the House of Lords affirmed there is no inherent jurisdiction to consent to medical treatment where an adult is incompetent but it was possible for the court to issue a declaration making the carrying out of a procedure lawful.

This case, that concerned whether or not a 36-year-old woman with the mental age of a child could be sterilized, considered the salient issues with Lord Brandon's analysis (at 55C-E) as follows:

> At common law a doctor cannot lawfully operate on adult patients of sound mind, or give them any other treatment involving the application of physical force however small ("other treatment"), without their consent. If a doctor were to operate on such patients, or give them other treatment, without their consent, he would commit the actionable tort of trespass to the person. There are, however, cases where adult patients cannot give or refuse their consent to an operation or other treatment. One case is where, as a result of an accident or otherwise, an adult patient is unconscious and an operation or other treatment cannot be safely delayed until he/she recovers consciousness. Another case is where a patient, though adult, cannot by reason of mental disability understand the nature or purpose of an operation or other treatment. The common law would be seriously defective if it failed to provide a solution to the problem created by such inability to consent. In my opinion, however, the common law does not so fail. In my opinion, the solution to the problem which the common law provides is that a doctor can lawfully operate on, or give other treatment to, adult patients who are incapable, for one reason or another, of consenting to his doing so, provided that the operation or other treatment concerned is in the best interests of such patients. The operation or other treatment will be in their best interests if, but only if, it is carried out in order either to save their lives, or to ensure improvement or prevent deterioration in their physical or mental health.

Interestingly, this leading case used the Bolam test (*Bolam* v. *Friern Hospital Management Committee* [1957] 2 All ER 118, [1957] 1 WLR 582), despite criticism by all three judges at the Court of Appeals that it was insufficiently stringent to ascertain if the proposed procedure was in that patient's best interests.

Lord Justice Butler-Sloss concluded that:

> In my judgment, that test [Bolam] is too wide. I, for my part, would respectfully adopt the test of a necessary operation set out in the judgment of Neill L.J., as that which the general body of medical opinion in the particular speciality would consider to be in the best interests of the patient in order to maintain the health and to secure the wellbeing of the patient. The criteria for making that medical decision are matters for the medical profession, but the final approval in the category of case including sterilization ought to be by the court.

However, the Lords did adopt the Bolam test despite the reservations expressed by the lower court, although Lord Jauncey concluded:

> I should like only to reiterate the importance of not erecting such legal barriers against the provision of medical treatment for incompetents that they are deprived of treatment which competent persons could reasonably expect to receive in similar circumstances. The law must not convert incompetents into second class citizens for the purposes of health care.

He also expressed the important proviso that "convenience to those charged with his care should never be a justification for the decision to treat."

Thus, in Re F, their Lordships made it clear that it was possible lawfully to treat incapacitated adults in England and Wales but the Court of Appeals held that if an irreversible process was contemplated, as a matter of good practice it was highly desirable that a declaration that the procedure was in that patient's best interests should be sought by those caring for the woman or intending to carry out the operation.

Having said this, Lord Brandon at 56D took the view that doctors were not required to do this as "if every operation to be performed, or other treatment to be given, required the approval or sanction of the court, the whole process of medical care for such patients would grind to a halt."

Hunger Strike

Of course, there may be occasions when patients are capable of making decisions on their own but the courts are asked to consider if they might be treated against their will. These instances are typically cases where that individual has either anorexia nervosa or is on hunger strike.

In *Secretary of State for the Home Department* v. *Robb* ([Family Division] [1995] Fan 127) it was held that:

> an adult of sound mind and capacity had a specific right of self-determination which entitled him to refuse nutrition and hydration; that that right was not diminished when he was a detained prisoner; that, although that right was not absolute but was to be balanced against potentially countervailing state interests in preserving life, preventing suicide and protecting innocent third parties, there was on the facts no countervailing interest to set in the balance and that, accordingly, since the prisoner was of sound mind and understood the consequences of his decision to refuse hydration and nutrition there was no duty on either the Home Secretary or the prison staff to provide him with nutrition or hydration against his will.

There was an apparently contrasting decision in *R.* v. *Collins Ex p. Brady* (LRM 355) where the view was taken that the decision of Brady to go on hunger strike was a feature or manifestation of his personality disorder and accordingly his force feeding had constituted necessary medical treatment for his mental disorder under s. 63 of the Mental Health Act 1983.

Conclusion

To summarize, it is not that patients who are unable to consent cannot be treated. Certainly, when there is an emergency the doctor who owes the patient a duty of care is ethically required to treat him/her or that practitioner may be guilty of serious professional misconduct with all the potential ramifications that accrue. Provided that the doctor goes no further than necessary to preserve life, he/she is protected by the doctrine of necessity, although case law indicates the limits to this treatment. Where the patient has long-term incapacity and his/her life is not at risk, the management has been made much more straightforward in Scotland. Unfortunately, in England and Wales the previous status quo is maintained and, whilst recent case law is of assistance in that treatment may lawfully be given, where the consequences of that intervention are irreversible the prudent doctor requires to seek advice as to whether an application needs to be made to the High Court, although that is not mandatory. What is essential is that the doctor can justify the treatment being in the patient's best interests even if concern has been expressed that the Bolam test may not be the way to do this.

See Also

Consent: Medical Examination in Custody; Confidentiality and Disclosure

Further Reading

General Medical Council (1998) *Seeking Patients' Consent: The Ethical Considerations*. London: General Medical Council.

General Medical Council (2001) *Good Medical Practice*. London: General Medical Council.

Confidentiality and Disclosure

I Wall, Ruislip, UK

Consent to Medical Treatment

Consent legitimizes otherwise illegal acts of physical contact which would form the basis of the criminal offense of assault and the civil wrong of battery. In addition, consent affirms ethical principles that seek to reflect choice, promote individual autonomy, and ensure the preservation of individual integrity.

Medical paternalism, which endorsed interventions pursuant to the profession's value judgment, has in the past been responsible for denoting consent to an issue of mere procedure rather than one of substance. The emergence of a more sophisticated society means that a respect for self-determination should now form the basis of good medical practice.

Valid Consent

The validity of any individual's act of consent for a proposed treatment depends on him/her having sufficient "capacity," possessing sufficient understanding or "knowledge," and agreeing "voluntarily," that is, not under coercion or subject to undue influence.

Capacity

There is a legal presumption that any person over the age of 18 who is not suffering from a mental incapacity is capable of giving consent for, or refusing, medical treatment unless there is evidence to the contrary.

An individual will only be regarded as having capacity to consent if sufficiently able to comprehend the nature, purpose, and effects of the proposed treatment as well as the consequences of nontreatment. Furthermore the individual must be in a position to retain the information provided, to believe the information, and to be able to balance it in order to arrive at a decision.

The concept of capacity emphasizes the decision-making process within the context of the particular decision the individual purports to make and not the decision itself. Thus, capacity must be commensurate with the gravity of the decision; the more complex the decision, the greater the capacity required to make it.

An individual's capacity to engage in therapeutic decision-making is, ultimately, a question of law and a matter to be decided by the courts.

Adults Lacking Capacity

An adult's decision-making ability may be impaired by a variety of mental and/or physical factors: enduring factors such as severe intellectual impairment, temporary factors such as acute mental illness, or the transient effects of unconsciousness, fear, or intoxication.

There are currently no provisions in England and Wales under which another party, be it next of kin or the courts, may give or withhold consent on behalf of an adult who lacks capacity.

Administering medical treatment in the absence of consent would ordinarily constitute an unlawful act, exposing the treating practitioner to formal legal censure and potentially depriving incapable individuals of the medical care they require. In these circumstances treatment may be justified under the common-law defense of necessity, and may be lawfully provided where it is in the patient's "best interests."

In the case of *F* v. *West Berkshire Health Authority* [1989] 2 All ER 545 the court, faced with an application to sterilize a seriously mentally disabled adult female, stated that, in general, treatment would be in a person's "best interests":

> if, but only if it is carried out in order either to save life or to ensure improvement or prevent deterioration in their physical or mental health.

The concept of best interests is, in this respect, capable of being broadly defined, and could be utilized to justify most types of therapeutic intervention. The court borrowed the peer-group test laid down in *Bolam* v. *Friern Hospital Management Committee* [1957] 2 All ER 118 as the appropriate standard for assessing "best interests" and what was "necessary." These principles conspire to afford the medical profession considerable influence in defining the limits of the "legal" defense of necessity.

The courts are the final arbiters on the issue of best interests and now approach the concept from a wider perspective, requiring an investigation into social, cultural, and religious dimensions, so that it no longer equates simply to best "medical" interests. The Bolam test still remains relevant in providing a basis on which the court can assess the "acceptability" of treatment advocated in individual cases.

The dictates of good medical practice now reflect this judicial holism, and an exploration of an

individual patient's premorbid beliefs, values, and feelings forms an essential ingredient in the assessment of consent.

Where the proposed treatment is contentious, such as nontherapeutic sterilization, withdrawal of artificial treatment, or where there is a dispute over the issues of best interests, any decision will require the sanction of the court.

In Scotland, statutory provisions (Adults with Incapacity (Scotland) Act 2000) allow for the appointment of proxies to look after the welfare of incapacitated individuals over the age of 16, and to consent to (but not refuse) medical treatment on their behalf where appropriate.

Emergency Treatment in Adults

In Re F the court recognized the qualitative differences between elective cases involving permanent loss of capacity and emergency situations where there is a temporary loss of capacity. In the latter situation, the doctrine of necessity is strictly limited to treatment that is "reasonably required" in the best interests of the patient. Any further or additional interventions should where possible (or reasonable) be postponed pending recovery of competence, however inconvenient that may be.

Mental Illness and the Mental Health Act 1983

Individuals suffering from a psychiatric illness should not automatically be regarded as incapable of consenting to (or refusing) medical treatment.

Individuals suffering from a defined mental disorder who are the subject of formal detention may be treated without their consent within the confines of s. 63 of the Mental Health Act 1983. While the form of "treatment" permissible has been widely interpreted and extends beyond routine psychiatric treatment, any such treatment must be strictly in respect of the patient's psychiatric condition and not a related physical condition. Additional statutory provisions under the 1983 Act serve to protect the patient's interests in respect of nonconsensual treatment relating to electroconvulsive treatment and "psychosurgery."

Adults Refusing Treatment

As logic would dictate, the law also recognizes the absolute and inviolable right of an individual not to be treated against his/her will. A competent adult has the right to refuse medical treatment even where a refusal appears unreasonable, irrational, and ultimately life-threatening, and refusals that may appear unreasonable to the healthcare professional should not automatically be equated with a lack of capacity or a psychiatric illness.

Where, however, the refusal appears profoundly irrational, or where temporary clinical factors are believed to have reduced the patient's capacity, or where the patient has an insufficiency of information on the consequences of his/her refusal, the practitioner should err on the side of preserving life or preferably seek further guidance from the court concerning the validity of the refusal.

In a series of cases (Re C (Adult: Refusal of Medical Treatment) [1994] 1 All ER 819; Re B (2002) 65 BMLR 149; and *St George's Healthcare Trust* v. *S* [1998] 3 All ER 673) where pregnant women had refused to consent to cesarean section, the courts expressed their commitment to support the mother's decision, even where the consequences would involve both mother and fetus perishing. The court's simplistic affirmation of general ethical principles of inviolability and self-determination was somewhat undermined by a degree of judicial *legerdemain*. The refusals were overridden by employing the fluid concept of capacity, while influential policy issues remained unaddressed.

Consent to Medical Treatment in Minors

16–17 years of Age

Under section 8 of the Family Law Reform Act (FLRA) 1969, individuals aged 16 years and 17 years (subject to satisfying the general principles in relation to valid consent outlined above) are entitled to consent to medical (and dental) treatment, without reference to those exercising parental responsibility.

In circumstances involving hazardous or complex treatments, good practice dictates the involvement of parents or carers, unless the young person refuses. This consent cannot be overridden by those exercising parental control but can be overridden by the court.

The Under-16s

The capacity of children below the age of 16 to consent to medical treatment depends on whether the child has achieved a sufficient understanding and intelligence to appreciate the purpose, nature, consequences, and risks of a particular treatment (as well as failure to treat), and that he/she has the ability to appraise the medical advice. This developmental concept, which became known as "Gillick" or "Fraser" competence (*Gillick* v. *West Norfolk and Wisbech AHA* [1986] 3 AC 112) is dependent on the child's chronological age, mental age, and emotional maturity, and is a recognition of a child's increasing autonomy with advancing age.

The treating practitioner is entrusted with deciding whether a child is competent and whether the

treatment proposed is in the child's best interests, and if of the opinion that the child is competent, the practitioner may proceed without the need to obtain additional parental consent.

In the interests of good practice the practitioner should, however, seek to persuade the child to inform his/her parents in respect of the proposed treatment, especially where such treatment is hazardous or likely to prove permanent.

In Scotland, the Age of Legal Capacity (Scotland) Act 1991 places the "Gillick" ruling on a statutory footing.

Refusal of Treatment (Minors)

Competent minors under the age of 18 may refuse treatment, though their wishes may be overruled by a "person" exercising "parental responsibility" (Children Act 1989), or the courts. In Re R (A minor: wardship consent to medical treatment) ([1991] 4 All ER 177), the court found that a 15-year-old ward of court suffering from mental health problems was not competent to refuse medical treatment. They expressed the view that even if the minor had been "Gillick" competent, the court (or "parent") would have had the power to overrule the decision to refuse treatment, as the power to consent and the power to refuse were qualitatively different. The former required the agreement of either party whereas an exercise of the latter power required both parties to refuse.

In Re W ([1992] 4 All ER 627) a 16-year-old who refused compulsory feeding for anorexia nervosa was deemed competent, though the court held that the FLRA 1969, which appeared to govern this case, did not address the issue of refusals (nor did the Gillick ruling, which was concerned with parental powers) and therefore did not prevent the court from exercising its considerable wardship powers to authorize treatment on the child's behalf. Where treatment is initiated against the child's wishes the court will wish to hear the minor's views (Re M (child refusal of medical treatment) (2000, 52 BMLR, 124)) and where treatment is authorized it is usually restricted to cases where the treatment is in the child's best interests and the child is at grave risk without treatment (Re L (A minor) ((1998) 51 BMLR)). The highly individual nature of theses cases usually requires an application to the court for a ruling on the "legality" of embarking on a particular course of treatment.

Children and Young Persons Lacking Capacity

Treating minors, who by virtue of their age are unable to make decisions about their medical treatment, requires the issue of consent to divest in those exercising parental responsibility. Such treatment, in any event, needs to be in the child's best interests.

Where those exercising parental responsibility refuse to consent on behalf of the child, and that refusal runs contrary to reasonable medical practice as well as the best interests (in the wider sense) of the child, it may be overruled by the courts.

Similarly, a doctor is not required to carry out treatment under parental, or the court's, wishes unless the treatment proposed is both clinically appropriate and in the child's best interests.

Knowledge and the Sufficiency of Information

The act of nonconsensual touching is sufficient to complete the common-law offenses of assault and battery. A failure to provide adequate information or to disclose any attendant risks of a proposed treatment may also vitiate consent and expose the practitioner to an allegation of battery. The courts have, however, indicated that battery is an inappropriate remedy in the context of a failure to disclose risks preferring "negligence" to be the correct action.

The duty to inform, advise, and warn of the risks of a medical procedure is one aspect of the general duty of care practitioners owe to their patients, though for the consent to be legally valid the patient needs to understand the purpose of the procedure in broad terms only (*Chatterton* v. *Gerson* [1981] (1 All ER 257)). In *Sidaway* v. *Bethlem Royal Hospital Governors and others* All ER 1985, 1, the plaintiff had suffered injury as a consequence of a risk inherent in her treatment, of which she had not been informed. She argued that the consent she had given was flawed as she had not received a full and detailed account of the procedure and had not been warned of all possible risks inherent in her treatment. The majority of the House of Lords confirmed that the test of liability in respect of a doctor's duty to warn of inherent risks in treatment was that laid down in Bolam, the quality and quantity of the information provided to a patient including risk warnings was a matter of clinical judgment. Provided a practitioner can demonstrate that he/she has acted in accordance with a practice accepted at the time as proper by a responsible body of medical opinion in relation to what information and what material risks are and are not conveyed, there is no civil liability.

As a matter of law, the court retained the right to overrule medical opinion on disclosure of particular risks where they were obviously necessary for any informed choice, and where a reasonably prudent practitioner would not fail to warn the patient.

The majority of the court concluded that English law did not recognize the doctrine of informed consent.

Informed consent has, however, found favor in other common-law jurisdictions where it is the courts that set the standards of disclosure and not the profession. Individual patients must be provided with information on all "material" or significant risks involved in their treatment.

In this respect the US courts have adopted the "reasonable patient" or "prudent patient" test rather then the "reasonable doctor" test, which is employed in the UK:

> A risk is material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or the cluster of risks in deciding whether or not to forgo the proposed therapy (*Rogers* v. *Whitaker* ([1992] 67 AWR 47)).

By this test, duty depends on "materiality" and that is assessed by reference to whether a reasonable person in the patient's position would be likely to attach significance to the risk. The character of the risk is therefore of great importance, thus special risks are more likely to be material as opposed to general risks, but in any event, materiality becomes a matter of law for the court to decide.

Confidentiality

Consent and confidentiality are both fundamental ethical principles of medical practice, founded on respect for individual autonomy. The notion of consent, furthermore, is a necessary starting point when considering disclosure of confidential information.

Patients have a right to expect medical information concerning them to be held in confidence. The duty to keep secret information acquired in the course of professional clinical interactions has venerable origins in the Hippocratic oath. The periodic enshrinement in international conventions (Declarations of Geneva (1947), Lisbon (1995), and Sydney (1968 and 1983)) that the duty has subsequently enjoyed is an explicit recognition of a professional undertaking prohibiting disclosure.

The duty of confidentiality, as an integral part of the diagnostic process, finds justification in "consequentialist" reasoning. Sufficient trust, it is argued, must inhabit the doctor–patient relationship in order to allow the unencumbered passage of sensitive information not only to ensure the integrity of the diagnostic process, but also to assuage patient concerns that details of embarrassing activities or criminal behavior will not be broadcast.

Legal Duty

A general duty of confidence arises by operation of the common law when a person discloses information to another in circumstances where there is a legitimate expectation that all identifiable information should not be disclosed (*Hunter* v. *Mann* ([1974] 1 QB 767)).

While the civil law provides a modicum of protection in the form of injunctive relief in respect of threatened breaches, the civil remedies available for the completed act are largely inadequate. Article 8 of the European Convention on Human Rights establishes a general requirement to protect the privacy of individuals and preserve the confidentiality of their health records, and while its provisions are enforceable through the courts, the jurisprudence awaits full exploration in the UK.

The law does not always reflect the appropriate ethical standards contained in professional codes of conduct. It is as an ethical concept that the duty of confidence purportedly finds its greatest protection under the auspices of the bodies that oversee professional conduct and standards. In the UK all practitioners must submit to the authority of the General Medical Council (GMC) and a failure to adhere to the strict rule of confidentiality may result in censure for serious professional misconduct.

Disclosure

The duty of absolute confidentiality, if it ever existed, is now much eroded. There are a number of exceptions to the ethical duty that may make the disclosure of confidential information appropriate, though should disclosure take place, it must be both lawful and ethical.

Disclosure with Consent

Where disclosure of confidential medical information does occur, general principles indicate that the "explicit" consent of the patient should be sought and only the minimum information sufficient for the purpose divulged.

An explicit request for nondisclosure should ordinarily be respected unless exceptional circumstances operate, such as where the patient's medical condition poses a threat to others or where the patient lacks competence and disclosure of relevant medical information is essential to the patient's medical interests.

Where patients have consented to healthcare, they are normally content for information to be disclosed to other members of the healthcare team who are under similar professional obligations. Where, however, the purpose is not directly concerned with the healthcare of a patient, it would be inappropriate to assume this "implicit" consent.

Disclosure in Connection with Judicial Proceedings

Disclosure must be forthcoming in both civil and criminal proceedings when ordered by a judge or certain tribunals; the doctor–patient relationship does not attract the privilege enjoyed by lawyers, allowing them to refuse to divulge certain confidences.

Where there is concern that disclosure of sensitive and irrelevant information may be ordered, or where information about third parties may be imparted, the doctor is entitled to make the appropriate representations. Ultimately, however, the court is the final arbiter on this matter, and a doctor's refusal to comply with judicial directions carries with it the prospect of being found in contempt.

The doctor has a legal obligation to cooperate with a coroner's judicial investigation of sudden or suspicious death.

Disclosures in the Public Interest

The notion of "public interest" provides a legal and ethical justification for the disclosure of confidential information under a variety of circumstances where the perceived benefits to society are seen to outweigh the doctor's individual duty of confidence.

Under common law, clinicians are permitted, but not obliged, to disclose personal information to assist the police in the investigation of serious crime in circumstances where a failure to disclose information would put the patient, or someone else, at risk of death or serious harm. The decision to disclose rests on balancing the competing public interests in the provision of a confidential service with the public interest in maintaining law and order.

A variety of public interest statutory exceptions to the nondisclosure rule exist in respect of criminal activities such as prevention of terrorism, and medical undertaking such as abortion and communicable disease reporting. In respect of the former, however, individual clinical information should not normally be forthcoming.

The positive duty imposed on doctors to provide information to the Drivers and Vehicle Licensing Authority (DULA) in the UK, where it is suspected that a patient is driving a vehicle contrary to medical advice, is based on the interests of protecting the public at large from the potential danger posed by this activity.

Where disclosures in the public interest are judged to be appropriate, they should be proportionate and limited to relevant details. Wherever possible the issue of disclosure should be discussed with the individual concerned and consent sought. Where this is not forthcoming, the individual should be told of any decision to disclose against his/her wishes.

Public interest considerations apply in respect of disclosures to statutory bodies involved in the collection of data necessary for planning and delivery of healthcare strategies and in respect of the valuable public health information passed to disease registries, though again, in general, patient consent for disclosure should be sought. In England and Wales the Health and Social Care Act 2001 now governs situations where it would be impossible or impracticable to obtain informed consent, where excluding those who refuse may detract from the essential value of the research, or where anonymized information is not sufficient.

Section 60 provides a legislative power to ensure that patient-identifiable information can be used without patient consent, subject to approval by the Patient Information Advisory Group – an independent statutory body. This statutory protection for disclosure provided without the consent is, however, only in respect of activities with a medical purpose, where the interests of public welfare outweigh issues of privacy.

Disclosure after a Patient's Death

The legal obligation to keep personal information confidential is extinguished on a patient's demise, though the ethical obligation survives.

In the event of a patient's death there is an obligation to disclose information in respect of National Confidential Enquiries, to assist the coroner in inquest proceedings, in death certification, public health surveillance, to relatives who request further information on the circumstances of death, or under The Access to Health Records Act 1990.

Audit, Teaching, and Research

Where identifiable information is to be disclosed for purposes whose aims are to benefit patient welfare such as research, epidemiology, financial audit, or administration, the express consent of the patient must be sought prior to disclosure. Patients should be provided with the appropriate information in relation to the utilization of their personal data, and given the opportunity to object to disclosure. In general, administrative and financial data should be maintained separately from clinical data and should be made anonymous.

The publication of case studies or medical photography in media within the public domain requires the explicit consent of the patient. Where such material is to be employed as a teaching resource then provided

features likely to identify the patient are removed, their use is not prohibited.

While the use of confidential patient information in medical research and public health surveillance is not directly associated with the healthcare that patients receive, their purposes are undoubtedly extremely important and the benefits they endow on society are incontrovertible.

Clinicians cannot, however, assume that patients who seek healthcare are content for their information to be used in these ways; indeed a disclosure to research workers may involve a breach of confidentiality (as well as transgressing the provisions of the Data Protection Act) even where the researchers may be medical practitioners themselves.

Statutes Expressly Protecting Confidentiality

There are strict regulations preventing the disclosure of identifying information obtained within the UK National Health Service, in respect of the examination or treatment for any sexually transmitted disease (including human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS)). While these conditions are of a particularly sensitive nature, the pragmatic basis for the restrictions rests on the understanding that the absence of confidentiality may discourage patients from seeking help, thereby facilitating the spread of infection.

Strict confidentiality provisions were deliberately drafted into the Human Fertilization and Embryology Act 1990 to ensure that the confidentiality of any person receiving licensed fertility services in the UK would be fully protected.

Inspecting Medical Records

The extent to which patients can access confidential clinical information about themselves is now largely governed by statute.

The Access to Medical Reports Act 1998 allows patients to see insurance and employment reports written about them by the doctor responsible for their usual medical care. This will afford the patient the opportunity to ensure that the report does not perpetuate potentially misleading statements.

The Access to Health Records Act 1990 gives patients, as well as a number of duly authorized third parties; access to manual health records made after the Act came into force. The Data Protection Act 1998 permits access to all manual health records whenever made, subject to specified exceptions.

The principal purpose of the Data Protection Act is to safeguard fundamental privacy rights by providing a framework that governs the processing of identifying information such as patients' records, whether electronic or paper.

The legislation is complex, but in summary it contains eight Data Protection Principles which state, *inter alia*, that all data must be processed fairly and lawfully, obtained and used only for specified and lawful purposes, and must be accurate, and where necessary, kept up to date. Patients have a right to be informed about the nature of the data held on them as well as its destination, and to consent to such use where appropriate.

Subject to certain criteria, the Act provides certain exemptions to its provisions for research purposes (s. 33 Data Protection Act). This is not a blanket exemption and, in this respect, there appears to be a degree of controversy over the interpretation of the precise scope of the Act and its potential to hamper legitimate research.

Inspection may be resisted in respect of all these Acts if disclosure is judged harmful to the patient's physical or mental health, or where the information relates to a third party.

See Also

Autopsy: Medico-legal Considerations; **Consent:** Medical Examination in Custody; Treatment Without Consent

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