

Chapter 20

THE THERAPEUTIC RELATIONSHIP: TREATMENT AND CONFIDENTIALITY

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20.01 Introduction

A personal therapeutic relationship is the most important aspect of the care and treatment of mentally disordered people. This chapter describes the most common forms of treatment; it examines the common law and the Mental Health Act to determine when treatment can be imposed with or without the consent of the patient; and it discusses the principle of confidentiality both from a professional and a legal perspective.

A. TREATMENT FOR MENTAL DISORDER

20.02 Definition of "Medical Treatment"

"Medical treatment", under section 145(1) of the Act, "includes nursing, and also includes care, habilitation and rehabilitation under medical supervision".¹ The term is, therefore, used to refer to a wide range of professional activities undertaken by doctors, nurses, clinical psychologists, occupational therapists and other mental health professionals. Apart from nursing, all such activities must be under medical supervision if they are to be legally classified as medical treatment. Arguably, any activity approved and supervised by the responsible medical officer or doctor in charge of treatment (see para. 6.17 *ante*) could qualify as medical treatment irrespective of its objective, for example, seclusion or restraint. Often there is a fine line between "medical treatment", "restraint" and "management". It is suggested that the courts would be likely to limit the use of the term "medical treatment" to activities with the objective of alleviating or preventing a deterioration in the patient's mental disorder, and which are within the range of treatments recognised and practised within the profession. The courts would probably look at the primary objective of the treatment in cases where it was said to have a number of purposes. (Not every activity supervised by a doctor can reasonably be deemed to be medical treatment).

Contemporary psychiatry is noted for its eclectic approach to the treatment of mental illness. Conventional medical treatments range from changing the social circumstances of the patient to causing physiological changes. It is intended here to provide only a brief description of the nature and objects of the most conventional forms of psychiatric treatment. For a more definitive examination the reader should refer to medical texts.

¹ The terms "habilitation" and "rehabilitation" in the 1983 Act replaced "training" in the 1959 Act. This was intended to broaden the scope of "medical treatment" particularly for mentally handicapped people. Rehabilitation may be described as a process of restoring the patient to his previous better state of mental health and social functioning. Habilitation is the raising of the patient to a level of mental health and social functioning he has never before attained.

20.03 Milieu Therapy

Milieu therapy refers to the possible beneficial effects on the well-being of the patient of the environment and social surroundings in the hospital. Milieu therapy is a scientifically imprecise term because it can refer to widely ranging and diverse hospital environments, making it difficult to conduct any properly controlled study of the effects on the individual.

20.04 Psychotherapy

Psychotherapy refers to psychological (as opposed to physical) methods for the treatment of mental disorders and psychological problems. It gives the patient the opportunity to talk about his problems and experiences with a doctor, psychologist, social worker or other therapist who is experienced in mental health. There are many different approaches including psychoanalysis, client-centred therapy, group therapy and counselling. Most share the views that the relationship between therapist and client is of prime importance, that the primary goal is to help personal development and self-understanding, rather than remove symptoms as such, and that the therapist does not direct the client's decisions.

20.05 Drug Treatment (Chemotherapy)

Psychotropic drugs are those used to affect mental functions, particularly mood: antidepressants, sedatives and tranquillisers are psychotropic. The administration of medicine for mental disorder to a patient to whom Part IV of the Mental Health Act applies is subject to the safeguards in section 58, if three months or more have elapsed since the first occasion when the medication was administered to him in a relevant period. (See further para. 20.21 below).

20.05.1 *Phenothiazines*

Phenothiazines are a group of chemically related compounds with various pharmacological actions. Some (including chlorpromazine—trade name Largactil¹) are major tranquillisers and are used to treat symptoms associated with such psychoses as schizophrenia and mania. Phenothiazines are usually given orally but can be administered intramuscularly (by injection). Long-acting phenothiazines (including fluphenazine—trade name Modecate) are usually administered intramuscularly and may have an effect ranging from 14–40 days. There is increasing evidence that, with prolonged use, the side effects can be serious and lasting, sometimes irreversible producing a condition known

¹ There are many trade names for each of the forms of medication given in the text. Some of the more commonly used trade names are indicated for the use of lay readers, but there is no significance in any trade name mentioned.

as tardive dyskinesia—*i.e.* difficulty in performing and controlling movements, particularly in the tongue, lips, jaw and extremities.

20.05.2 *Minor tranquillisers*

Minor tranquillisers, such as benzodiazepines (which include chlordiazepoxide—trade name Librium—and diazepam—trade name Valium) produce a calming effect and are used to treat neuroses and to relieve anxiety and tension due to various causes. Some drowsiness and dizziness are side effects, and prolonged use can cause dependence.

20.05.3 *Antidepressants*

Antidepressants are used to alleviate the symptoms of depression. They are characteristically slow to act, sometimes taking up to two or three weeks to take effect. The most widely prescribed antidepressants are a group of drugs called tricyclic antidepressants. These include amitriptyline—trade names Tryptizol, Saroten and Elatrol—and imipramine—trade name Tofranil. Side effects commonly include dry mouth, blurred vision, constipation, drowsiness, and difficulty in urination. Monoamine oxidase inhibitors (MAOI) are another main group of antidepressants. These prevent the activity of the enzyme monoamine oxidase in the brain tissue and therefore affect mood. They include phenelzine—trade name Nardil. Their use is restricted because of the severity of their side effects. These include interactions with other drugs (*e.g.* amphetamine) and foods containing tyramine (*e.g.* some cheeses) to produce a sudden increase in blood pressure. Other commonly prescribed medications for depression are Lithium and Fluoxetine Hydrochloride—trade name Prozac.

20.06 **Electroconvulsive Therapy (ECT)**

In electroconvulsive therapy an electric current is passed through the front part of the brain in order to produce a convulsion. The convulsion is almost always modified by giving a muscle relaxant drug and an anaesthetic to minimise the risk of physical damage during the convulsion; failure to modify the convulsion in this way is ethically controversial, and could only rarely be justified.¹ ECT is often given in a course of 6–12 sessions and is administered once or twice weekly. The means by which ECT acts is not yet known. However, it has been demonstrated to be a successful empirical treatment for people suffering from the more severe and endogenous depressions,² although there is

¹ See generally L. Gostin (1981) A Jurisprudential and Ethical Examination of ECT, in R. Palmer, ed., *Electroconvulsive Therapy: An Appraisal*, pp. 288–302, University Press, Oxford.

² See *e.g.* Royal College of Psychiatrists (1977) Memorandum on the Use of Electroconvulsive Therapy, *Brit. J. Psychiat.*, vol. 131, pp. 261–272; Royal College of Psychiatrists (1989) *The Practical Administration of Electroconvulsive Therapy (ECT)*, Gaskell, London.

some evidence that its effects may not be long-lasting.¹ It is reported to work at least as well as the most effective antidepressant medication and with more rapid results. It is occasionally used in the treatment of schizophrenia and mania, although the evidence to demonstrate its efficacy for these forms of mental disorder is equivocal. Side effects include temporary confusion, impairment of memory and headache. These adverse effects are reduced by unilateral treatment, in which the electrical current is passed only through the non-dominant hemisphere of the brain. Concern has been expressed about the standard of equipment used and the administration of ECT.² The treatment cannot be given to detained patients to whom Part IV of the Act applies without complying with section 58 of the Act. (See further para. 20.21 below).

20.07 Psychosurgery

Psychosurgery is the selective surgical destruction of nerve pathways or normal brain tissue with a view to influencing behaviour. The surgery can be performed using a free-hand method. However, in contemporary psychosurgery a much more precise and selective lesion can be made using a stereotactic approach. A stereotactic instrument positions the head in a fixed plane to enable the surgeon, with the aid of three dimensional maps and x-ray guidance, to insert probes into the brain. When the tip of the brain is adjacent to the chosen site, the destructive lesion is made using electricity, cold (cryosurgery), heat (diathermy or radio frequency), a cutting wire or radiation. The modern operation is used in the treatment of severe depression, obsessional neuroses, and chronic anxiety, where very severe emotional tension has not been relieved by other treatments and, rarely, for intractable pain. Because of the ethical difficulties there have been no properly controlled studies of its efficacy. Psychosurgery is irreversible and side effects using older free-hand methods can be severe including changes in personality towards apathy and dullness. Serious side effects are reported to be uncommon with modern selective procedures.³ In the three-year period 1979–1982, psychosurgery was performed on 207 informal patients and four detained patients in England and Wales.⁴ The practice of psychosurgery is now strictly regulated by section 57 of the Act. (See para. 20.20 below).

¹ See Johnston, et. al. (1980) The Northwick Park Electroconvulsive Therapy Trial, *The Lancet*, ii, pp. 1317–20.

² See J. Pippard & L. Ellam (1981) *Electroconvulsive Therapy in Great Britain*, Gaskell, London (summarised in the *Brit. J. Psychiat.*, vol. 139, pp. 563–68) and Royal College of Psychiatrists (1989) *The Practical Administration of Electroconvulsive Therapy (ECT)*, Gaskell, London.

³ See Bridges & Bartlett (1977) Psychosurgery: Yesterday and Today, *Brit. J. Psychiat.*, vol. 131, pp. 249–58; Bartlett, Bridges and Kelly (1981) Contemporary Indicators for Psychosurgery, *Brit. J. Psychiat.*, vol. 138, pp. 507–511. Cf., Gostin (1982) Psychosurgery: A Hazardous and Unestablished Treatment? *J. Soc. Wel. Law*, pp. 83–95.

⁴ See Clarke (1982) *Official Report of the Special Standing Committee on the Mental Health (Amendment) Act 1982*.

20.08 Behaviour Modification

The term "behaviour modification" is open to varied interpretations. In conventional terms it refers to techniques for the management and treatment of patients developed in systematic studies of human and animal behaviour, emphasising the environmental determinants of behaviour. The aim of behaviour modification is systematically to use or to manipulate events or occurrences in a patient's environment with a view to achieving a specific modification in behaviour rather than improvement or cure in a conventional medical sense. As such the treatment should be based upon inter-professional agreement, primarily among psychiatrists, psychologists and nurses. Token economy techniques are among the best known methods of modifying behaviour. It is a system often applied to all individuals in a social unit such as a hospital ward. A tangible signal (token) is given to a patient immediately after he produces an appropriate pattern of behaviour, seeking to reinforce (reward) that behaviour and thus increase its frequency. The tokens are retained by the patient, and may be exchanged for goods or privileges additional to those ordinarily allowed.¹

Some behaviour modification has proved controversial because the goals of the programme, or the methods used to attain those goals, are thought to be unacceptable.² The question to consider is whether the goals decided upon are concerned primarily with the needs of the patient or whether the convenience of the staff and running of the institution are paramount; these need not be in conflict but it is suggested that this should not be taken for granted. The methods of behaviour modification may involve re-scheduling or restricting the patient's access to food or money, curtailing visits or leave, the use of seclusion or physical restraint or causing the patient to experience a degree of discomfort or pain. Professionals have been advised, *inter alia*, to ensure that full information concerning the programme is available to the patient, his relatives and others; there is a legally sufficient consent to the programme; there is a formal framework for review and scrutiny of the programme; and there is adequate training for professionals involved in the design and implementation of the programme.³ Part IV of the Act and the accompanying Regulations (reg. 16) do not refer to behaviour modification, and it is thus unregulated.

Technically, patients detained under sections of the Act to which Part IV applies (see para. 20.18 below) can be compelled to participate in behaviour modification programmes. However, voluntary co-oper-

¹ *Report of a Joint Working Party to Formulate Ethical Guidelines for the Conduct of Programmes of Behaviour Modification in the NHS* (1980; Zangwill), Appendix I.

² See e.g. *Report of the Professional Investigation into Medical and Nursing Practices on Certain Wards at Napsbury Hospital, near St. Albans* (1973), para. 55.

³ *Report of a Joint Working Party to Formulate Ethical Guidelines for the Conduct of Programmes of Behaviour Modification in the NHS* (1980), para. 45.

ation is usually an essential part of successful behaviour modification. Informal patients and other patients not subject to Part IV must voluntarily consent to behaviour modification.

The Code of Practice (paras 19.1–19.8) recommends that behaviour modification programmes should be part of a previously agreed plan of treatment, and not a spontaneous reaction to a particular type of behaviour. A patient's consent to participate should always be sought as part of a process of full discussion. A patient who is subject to Part IV may be given behaviour modification without consent only in carefully justified circumstances. The RMO should first seek the advice of an independent person qualified and experienced in behaviour modification techniques such as a psychologist who is not a member of the clinical team.

Behaviour modification programmes or other psychological treatments should never deprive a patient of food, shelter, water, warmth, a comfortable environment, confidentiality or reasonable privacy (both physical and in relation to the patient's personal feelings and thoughts).

20.08.1 *Time-out*

Time-out is a behaviour modification technique which denies a patient for a short period (lasting no more than 15 minutes) opportunities to participate in or to obtain positive reinforcers following an incident of unacceptable behaviour. Time-out usually occurs directly following the unwanted behaviour, and the patient is returned to his original environment shortly thereafter.

Hospitals should have clear written policies on the use of time out. Time out should never include the use of a locked room. Time out should be clearly distinguished from seclusion, which is for use in an emergency only and should never form part of a behavioural programme. All staff working in units which use behaviour modification techniques must be familiar with the principles of time out and the distinction between time out and seclusion. Time out should not normally take place in a room which is used for seclusion on other occasions. It should be seen as one of a range of planned methods of managing a difficult or disturbed patient, and not as a spontaneous reaction to such behaviour. The ultimate goal should be to help the patient to lead a more normal, less restrictive life. (Code of Practice, paras 19.9–11).

20.08A *Seclusion*

Seclusion has been defined as “the supervised confinement of a patient specifically placed alone in a locked room for a period at any time of the day or night for the protection of self or others from serious

harm”.¹ Short term seclusion, sometimes referred to as “time out” or “cooling down” is sometimes used particularly in mental handicap hospitals as a method of behaviour modification (see para. 20.08 above) or to have a short period to calm down. Longer periods of seclusion are used particularly in the special hospitals and regional secure units for patients during violent episodes. The European Commission of Human Rights in *A v. the United Kingdom*² accepted a friendly settlement which included a requirement to introduce new guidelines for seclusion at Broadmoor Hospital. This led to a Department of Health review of special hospital seclusion procedures which is discussed at para. 3.12A *ante*.

The Code of Practice (paras 18.15–18.23) recommends that the decision to use seclusion should be initially made by a doctor, the nurse in charge of the ward, a nursing officer or senior nursing officer. A doctor must always attend immediately. The patient’s safety and comfort while in seclusion is of paramount importance. The seclusion room must be safe and secure for the patient. It must have adequate heating, lighting, ventilation, and seating. The patient also must be adequately clothed. A nurse must be able to see and hear the patient, and be present at all times when the patient is sedated.

Seclusion must be ended as soon as it is safe to do so. The patient’s condition must be observed and documented every 15 minutes. If seclusion needs to be continued, a review should occur every two hours by two nurses, and every four hours by a doctor. If seclusion continues for more than eight hours consecutively or for more than twelve hours intermittently over a period of 48 hours, an independent review must be carried out. The review must be made by the RMO, and a team of nurses and other health care professionals who were not directly involved in the patient’s care at the time. If the review team are not in agreement the Unit General Manager must conduct a prompt and independent review.

The nurse in charge of the ward (countersigned by the doctor and a unit manager) must keep detailed records of the reasons for, and conditions of, seclusion.

20.09 Sterilisation

Sterilisation is an operative procedure performed for the purpose of rendering a person incapable of producing offspring—for example, by cutting or sealing the vasa deferentia in men (vasectomy) or the fallopian tubes in women (salpingectomy). Sterilisation cannot be regarded as a “medical treatment given to him [the patient] for the mental disorder from which he is suffering” within the meaning of

¹ DHSS (April 1985) *Review of Special Hospitals Seclusion Procedures*, para. 3.6.

² Application No. 6840/74. Report of the European Commission of Human Rights, 16 July 1980.

section 63. (See further para. 20.19 below). Therapeutic sterilisation is for the person's physical health or general mental health and not a specific treatment for mental disorder; further, non-therapeutic sterilisation, given for example to a mentally handicapped person, often has social as opposed to specific medical objectives.¹

The House of Lords decided two sterilisation cases which attracted extensive public interest: *Re B. (A Minor)*,² a wardship proceeding concerning sterilisation of a minor, and *F. v. West Berkshire Health Authority*³ (sterilisation of an adult).⁴ These two cases are discussed at paras 20.15B–20.16 below.

20.09A Treatment Plans

The responsible medical officer or the doctor in charge of treatment should consult with the multidisciplinary team in order to devise a plan of treatment. Ultimately it is the doctor's responsibility to ensure that treatment is provided lawfully, efficaciously, and without undue risk to the patient.

Individual plans of treatment should be formulated for all patients and recorded on the clinical records. The plan of treatment should include a description of short and long term objectives and how those goals will be achieved through a variety of medical, social, behavioural, and nursing interventions. The doctor should periodically review the treatment plan to be sure that the objectives are being met, and the patient is not suffering from unreasonable adverse effects. Whenever possible, the treatment plan should be openly discussed with the patient and, with his consent, if he is capable of giving it, appropriate relatives concerned about the patient. The patient can often make a valuable contribution to the plan of treatment.

Plans of treatment for informal as well as detained patients represent good mental health practice (Code of Practice, paras 15.1–15.7). Part IV of the Act also provides for plans of treatment of a more technical kind which apply to consents or certificates given under section 57 or 58. (See further para. 20.24 *post*).

¹ The distinction between therapeutic and non-therapeutic sterilisation was expressly rejected as "elusive" by the Court of Appeal in *Gold v. Haringey Health Authority* [1987] 2 All E.R. 888. The doctor has no greater obligation to disclose information to the patient because the procedure may be for personal or social, rather than strictly therapeutic, reasons. See further para. 20.12–2 below.

² [1988] A.C. 199, [1987] 2 All ER 206. See further para. 20.15B.2 below. For a discussion of this and other sterilisation cases see Grubb and Pearl (1987) *Sterilisation and the Courts*, *Camb. L. J.* Vol. 46(3), pp. 439–464.

³ [1990] 2 A.C. 1. See further para. 20.16 below.

⁴ For other sterilisation cases see *In re T* (1987) *The Times* May 26, 1987, *per* Latey J; *In re X* (1987) *The Times*, June 4 1987, *per* Reeve J; *T. v. T* [1988] 1 All E.R. 613; *Re P (a minor) (Wardship: Sterilisation)* [1989] 1 F.L.R. 182; *Re M (a minor) (Wardship: Sterilisation)* [1988] 2 F.L.R. 497.

B. CONSENT TO TREATMENT UNDER THE COMMON LAW

20.10 Applicability of Common Law Principles to Mentally Disordered Persons

Part IV of the Mental Health Act 1983 regulates the circumstances under which certain detained patients can be treated without their consent. **Where the statute applies its provisions override the common law; but where the Act does not apply the ordinary common law remains in force.** Part IV of the Mental Health Act does not apply to treatment given to **informal patients** and certain short stay detained patients; it also does not apply to the treatment of any patient for a **physical illness**. The fact that Parliament felt it necessary to legislate to determine the circumstances in which certain detained patients could be given treatment without consent indicates that, where Parliament remained silent, it did not intend to alter the existing common law position. The boundaries of the common law, therefore, need to be explored, for they continue to apply to patients who fall outside of the scope of Part IV of the Act; the great majority of mentally disordered patients in hospital are not affected by Part IV and it is to be expected that the courts would apply the ordinary common law in determining

their right to bring,¹ and to sustain, an action in tort. This would place such patients in the same legal position as a patient receiving treatment for physical illness in a general hospital.² The threshold issue is whether Part IV of the Mental Health Act is applicable to the particular patient and to the treatment to be administered. This issue is examined at paras. 20.18–20.19 below.³

20.11 Trespass to the Person: The Basic Principles

The common law has historically protected the personal or bodily interests of the individual through trespass to the person.⁴ Trespass effectuates the common law's regard for personal self-determination; the offensive touching may benefit the individual (as with a medical procedure which is indicated and performed with reasonable care)⁵ but will still amount to an actionable battery unless the actor has a justification—for example, the consent of the plaintiff. The scope of the personal interest to be protected under the common law can be expressed as follows: the law will protect the judgement of physical self-interest made by a competent adult; it will not countenance the substitute judgement of a doctor or any other person such as a near relative, however benevolent in intent.⁶ Arguably, this principle will be applied even where medical intervention is designed to save the life of the patient,⁷ except for cases of urgent necessity where consent cannot be obtained.

Consider the cases of *Secretary of State for the Home Department v.*

¹ The right of a patient to bring an action in respect of a treatment given outside the scope of Part IV would be unlikely to be affected by s. 139. But note that s. 139 would clearly apply in the case of any treatment given within the scope of Part IV. See further paras. 21.25–21.26 *post*.

² The legal position of a patient admitted, for example, under s. 4 or a guardianship patient, would be equivalent to that of an informal patient.

³ A most helpful discussion paper on *Consent to Treatment* was issued by the Mental Health Act Commission in July 1985.

⁴ For a discussion of trespass to the person and the torts of battery and assault, see paras. 20.12–20.16 below; and for consent to restraint see paras. 21.02 and 21.05 *post*.

⁵ See P. Devlin (1962) *Samples of Law Making*, University Press, Oxford, p. 90. (The common law “does not consider that an act done without a person's consent but for his benefit is deserving of reward or even of immunity from the action of trespass. The Good Samaritan is a character unesteemed by the English law”.)

⁶ See e.g. *Smith v. Auckland Hospital Board* [1965] N.Z.L.R. 191 at 219, per Presson, J. (A patient must “always retain the right to decline operative investigation or treatment however unreasonable or foolish this may appear in the eyes of his medical advisors.”)

⁷ *Leigh v. Gladstone* (1909) 26 T.L.R. 139 is sometimes cited to establish the broad principle that consent may be dispensed with in respect of life saving procedures. The case, which concerned the forcible feeding of prisoners, also enunciated a duty to save life. See *Mulloy v. Hop Sang* [1935] 1 W.W.R. 714 (Alta. S. Ct. App. Div.) See also Zellick (1976) *The Forcible Feeding of Prisoners*, *Public Law*, vol. 153, pp. 162–72; Kennedy (1976) *The Legal Effect of Requests by the Terminally Ill and the Aged not to Receive Further Treatment from Doctors*, *Crim. L. Rev.* 217. Thorpe J in *Secretary of State for the Home Department v. Robb* [1995] 1 All E.R. 677 rejected *Leigh v. Gladstone* as an applicable modern authority.

*Robb*¹ and *Re C (Refusal of medical treatment)*² in support of the proposition that competent persons have the right to self-determination in rejecting even life sustaining treatment.³ In *Robb*, the Home Secretary sought a declaration that it would be lawful to refrain from treating a prisoner, diagnosed with a personality disorder, who had embarked on a hunger strike. The court ruled that it was lawful for the Home Office to observe and abide by the refusal of the defendant to receive nutrition and that it could lawfully abstain from providing hydration and nutrition as long as the defendant retained the capacity to refuse them. When an adult of sound mind refuses treatment, however unreasonably, 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. The defendant's right to self-determination was not diminished by his status as a detained prisoner.⁴

In *Re C (Refusal of medical treatment)* a detained patient with schizophrenia refused to consider amputation of his gangrene-infected leg. The court granted an injunction restraining the hospital from amputation without the patient's express written consent. The presumption of the patient's right to self-determination was not displaced; even though the patient's general capacity was diminished by his schizophrenia, he sufficiently understood the nature, purpose, and effects of the treatment to judicially recognize his refusal of a potentially life-saving treatment.

Consent is a defence to a civil action in battery, although not always so in the criminal context. (See further para. 21.07 *post*). Consent may be given orally or in writing; a written instrument stating a person's consent is not the consent itself but merely evidence of it which can be negated, for example, with evidence of duress or incompetency. A patient's consent may be inferred from his behaviour if he presents

¹ [1995] 1 E.R. 677, 1 F.C.R. 577, 1 F.L.R. 412, Family Division, 4 October 1994.

² [1994] 1 All E.R. 819, 1 W.L.R. 290, 1 F.L.R. 31, 15 B.M.L.R. 77, Fam Law 231, 2 F.C.R. 151, Family Division, 14 October 1993.

³ See *Airedale NHS Trust v. Bland* [1993] A.C. 789, 1 All E.R. 821, [1993] W.L.R. 316, [1993] 1 F.L.R. 1026, per Keith, LJ (holding that doctors could lawfully discontinue all life-sustaining treatment and medical support measures designed to keep a person alive in a persistent vegetative state); *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, [1992] 4 All E.R. 649, [1992] 3 W.L.R. 782 (a Jehovah's Witness case holding that although an adult patient was entitled to refuse consent to treatment irrespective of the wisdom of the decision, for such refusal to be effective she had to be competent to make that decision).

⁴ *Leigh v. Gladstone* (1909) 26 T.L.R. 139 is sometimes cited to establish the broad principle that consent may be dispensed with in respect of life saving procedures. The case, which concerned the forcible feeding of prisoners, also enunciated a duty to save life. See *Mulloy v. Hop Sang* [1935] 1 W.W.R. 714 (Alta. S. Ct. App. Div.) See also Zellick (1976) *The Forcible Feeding of Prisoners*, *Public Law*, vol. 153, pp. 162-72; Kennedy (1976) *The Legal Effect of Requests by the Terminally Ill and the Aged not to Receive Further Treatment from Doctors*, *Crim. L. Rev.* 217. Thorpe J in *Secretary of State for the Home Department v. Robb* [1995] 1 All E.R. 677 rejected *Leigh v. Gladstone* as an applicable modern authority.

himself before the medical practitioner and does not verbally or physically resist procedures which are ordinarily and reasonably expected by circumstances attendant in the immediate doctor-patient relationship, *e.g.* by rolling up the sleeve and putting the arm out to receive an injection. Consent, whether expressed or implied, may be withdrawn at any time prior to or during the medical procedure or examination. The principle of valid consent comprises the following components: information, competency, voluntariness and specificity.

20.12 Information

The doctrine of "informed consent" in the United States and Canada suggests that the patient must be given a clear explanation of the nature, purpose, effects and material risks attendant to a medical procedure. The law in England and Wales does **not** recognise a doctrine of informed consent.¹ The consent must be 'real', in the sense that the patient must know what he is consenting to; where information is so incomplete or inaccurate as to misinform the patient of the very nature of the treatment the consent is undermined.² Once the patient is informed in broad terms of the nature of the procedure, and gives his consent, that consent is legally effective.³ Thus, a consent is not vitiated by a failure on the part of the doctor to give the patient sufficient information about the effects and risks before the consent is given. It is only if the consent is obtained by fraud or by misrepresentation of the nature of what is to be done that it can be said that an apparent consent is not a true consent.⁴

¹ *Sidaway v. Bethlem Royal Hospital Governors and others* (1985) *Times Law Report*, Feb. 22, 1985, H.L., affirming [1984] 1 All E.R. 1018. See Kennedy (1984) *The Patient on the Clapham Omnibus*, *Mod. L. Rev.*, vol. 47, pp. 454-71; Robertson (1981) *Informed Consent to Medical Treatment*, *L.Q.R.* vol. 97, pp. 102-126; Skegg (1975) *Informed Consent to Medical Procedures*, *Med. Sci. & Law*, 15, vol. 124; M. Brazier (1979) *Informed Consent to Surgery*, *Med. Sci. & Law* vol. 19, pp. 49-54. See further para. 20.12.1 below.

² See *Cull v. Butler* [1932] 1 B.M.J. 1195 (Consent to a curettage is unacceptable if a hysterectomy is performed); *Michael v. Molesworth* [1950] 2 B.M.J. 171 (Consent given to a particular surgical specialist is unacceptable if a house surgeon performs the operation). *Hamilton v. Birmingham R.H.B.* [1959] 2 B.M.J. 456. The patient is entitled to assume the treatment is intended for his benefit. If the patient is not informed that the intervention is not in his interests but is in the interests of science or medicine generally or for the doctor's own gratification, there is no consent at all. *R. v. Rosinski* (1824) 1 Lewin 11, 1 Mood 19; *R. v. Case* (1850) 4 Cox C.C. 220; *R. v. Maurantonio* (1967) 65 D.L.R. (2d.) 674. If the information provided suggests the treatment is safe, but it has significant risks and is not fully established, there is no consent. *Halushka v. University of Saskatchewan* (1965) 53 D.L.R. (2d.) 436. See also cases cited in *Reibl v. Hughes* (1980) 114 D.L.R. (3d.) 1, at 10.

³ *Chatterton v. Gerson* [1981] Q.B. 432, [1981] 1 All E.R. 257, at 265.

⁴ *Chatterton v. Gerson* [1981] 1 All E.R. at 265; *Wells v. Surrey A.H.A.*, *The Times*, July 29, 1978 (doctor was negligent in failing to give "proper advice" before performing a sterilisation). See *Reibl v. Hughes* (1980) 114 D.L.R. (3d.) 1, at 10. (Actions in battery should be confined to cases where there is no consent or where the doctor went beyond the consent. Unless there has been misrepresentation or fraud to secure consent, failure to disclose even serious risks should go to negligence rather than to battery).

20.12.1 *Duty of disclosure*

The courts have consistently stated that once a broad terms explanation of the treatment is given, the consent is legally effective and no action in trespass will lie. (See para. 20.12 above). The cause of action on which to base a claim for failure to explain the risks and implications is negligence, not trespass. The traditional test of negligence in the context of medical diagnosis and treatment was stated by McNair, J. in *Bolam v. Friern Hospital Management Committee*:¹ “the standard of the ordinary skilled man exercising and professing to have that special skill.” A doctor is not negligent if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular speciality. It is enough for a doctor to avoid liability if he establishes by expert evidence that there exists a body of respectable medical opinion which would support his action. It does not matter that there may be another body of respectable opinion against the action. The *Bolam* direction was considered and approved by the House of Lords in *Whitehouse v. Jordan*² and in *Maynard v. West Midlands Regional Health Authority*.³

The *Bolam* decision was re-examined and clarified by the House of Lords in *Bolitho v. City & Hackney Health Authority*.⁴ The decision focused on the words “responsible” and “respectable.” Under *Bolitho*, the court must consider whether the body of opinion relied upon by the doctor is capable of withstanding logical analysis. Therefore, in examining evidence presented by expert witnesses, which may be diametrically opposed, the court can examine the reasonableness of the opinions presented. Indeed, a doctor may be held liable for negligence even if a respectable opinion would support his action, if in the judgment of the court that “respectable” opinion is illogical or unreasonable. It is not sufficient to say that because expert opinion would support his action, the doctor is not negligent.

It is clear, therefore, that the test of negligence in cases of diagnosis and treatment is what a reasonable member of the medical profession would do. The question arises whether this is the test to be applied to that other aspect of the doctor/patient relationship—the disclosure of information to the patient of the effects and risks of the proposed treatment. The question is of substantial importance because if the medical test is adopted, the duty to disclose information is based upon a norm of accepted medical practice rather than upon the patient’s right to minimal information. Basic information is necessary if the patient is to exercise an informed choice among alternative treatments. The law should itself set the standard for proper disclosure which should

¹ [1957] 1 W.L.R. 582.

² [1981] 1 All E.R. 267.

³ (1983) *The Times*, May 9, 1983.

⁴ [1998] AC 232, [1997] 4 All ER 771, 3 WLR 1151, 38 BMLR 1.

be based upon the information the *patient* would regard as material in reaching a decision consistent with his own view and values.¹

Before *Sidaway v. Bethlem Royal Hospital and the Maudsley Hospital Health Authority and Others*² there had been no consideration by the Court of Appeal or the House of Lords as to whether the medical test of negligence applied to disclosure of information. The medical test had been applied by Bristow, J. in *Chatterton v. Gerson*³ and by Hirst, J. in *Hills v. Potter*.⁴ In *Sidaway* the House of Lords broadly accepted the medical standard—*i.e.*, whether there is a body of respectable medical opinion which would support the disclosure of information in the circumstances of the case (the *Bolam* test). But a court could come to the conclusion that the disclosure of a particular risk is so obviously necessary to an informed decision by the patient that no reasonably prudent doctor could fail to make it. Doctors are certainly under a legal duty to disclose to a patient any substantial risk involving grave adverse consequences. The test assumes that both the chances of the treatment producing an adverse effect are high⁵ and that the potential adverse effect is serious. If the risk of an adverse effect is slight or insignificant⁶ the information can be withheld if that is an accepted practice within the community of medicine.

The House of Lords in *Sidaway* produced four separate opinions, and only Lord Scarman accepted that the doctrine of informed consent had any place in the English law. The Lords' judgments are unhelpful for they fail to clarify for the doctor as well as the patient the kind of disclosure which the courts might in future consider it necessary for the doctor to make. It is clear, however, that the medical profession could set its own standard of disclosure unless it was manifestly inadequate, thus failing to ensure that the information given will best help the patient to make a rational decision.

The fact that a responsible body of medical practice does support the actions of the clinician is not by itself necessarily conclusive. In *Smith v. Tunbridge Wells Health Authority*,⁷ the failure to warn a 28 year old man of the risks of impotence subsequent to surgery upon a rectal prolapse was found to constitute negligence. It was held that, while some surgeons were not providing warnings of that risk at that time,

¹ See Kennedy (1984) *The Patient on the Clapham Omnibus.*, *Mod. L. Rev.*, vol. 47, pp. 454–71.

² *Times Law Report*, Feb. 22, 1985. H.L. *affirming* [1984] 1 All E.R. 1018, C.A.

³ [1981] 1 All E.R. 257.

⁴ [1983] 3 All E.R. 716.

⁵ Lord Bridge and Lord Keith in *Sidaway* gave as an example of a "substantial risk" the ten per cent risk of a stroke from the operation in *Reibl v Hughes* (1980) 114 D.L.R. (3d.) 1.

⁶ In *Sidaway* there was a 1 to 2 per cent risk of ill effects, ranging from the mild to the catastrophic; there was no legal duty to disclose such risks.

⁷ [1994] 5 Med. L.R. 334.

nonetheless the omission to inform in this particular case was “neither reasonable nor responsible”.

The House of Lords in *Bolitho* subsequently illustrated the fact that there is greater judicial willingness to scrutinise the opinion expressed by the body of professional practice.¹ Lord Browne Wilkinson stated that:

“In particular where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible. I emphasise that in my view it will be very seldom right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable.”

In this case Lord Browne Wilkinson excluded from his discussion the issue of disclosure of risk. However, the application of *Bolitho* to diagnosis and treatment was considered recently in the decision of *Pearce v. United Bristol NHS Trust*.² Here the Court of Appeal looked at both the decisions in *Bolitho* and the earlier House of Lords judgment in *Sidaway*. Lord Woolf held 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, if the information is needed so that the patient can determine for him or herself as to what course that she should adopt.”

On the facts of that particular case, the plaintiffs failed to establish negligence. The woman, whose delivery was overdue, was advised against a caesarian section. Her child was delivered still born. It was held that while there was between a 1 and 2 in 1000 risk of stillbirth by delay of the delivery through waiting for a natural delivery, this was not considered “significant” by the medical experts. Had the information concerning the risk of stillbirth been disclosed, the evidence suggested she would still have made the choice to go ahead with a natural delivery. Nonetheless the approach taken by the Court of Appeal in this case indicates that this decision may again be regarded as a further step towards a broader duty of disclosure upon clinicians.³ Jones has argued that the effect of the judgments is that of a combination of the “prudent patient” standard with the reasonable doctor standard and that, in the light of this case, it could be argued that “no reasonable doctor would

¹ *Bolitho v. City and Hackney Health Authority* [1997] 1 W.L.R. 1151.

² [1999] P.I.Q.R. P53, CA.

³ See further the discussion of this issue by A. Grubb [1999] 7 *Medical Law Review* 61.

fail to disclose a risk regarded as significant by a reasonable patient”.¹ Moreover, it appears to be the case that the risk does not necessarily have to be such that the patient would have changed their mind had they known about this particular risk, but rather that it could be sufficient if this risk is one which is *relevant* alongside other factors in reaching a decision.²

The implications of the judgments in *Bolitho* and *Pearce* are yet to be explored by the courts. However, the prospect of such enhanced judicial scrutiny may suggest that in the future it will become increasingly difficult to justify withholding information regarding the risks of treatment from patients. This may be particularly the case in the light of the fact that the Human Rights Act 1998 comes into force in October 2000. It may also be reflective of the fact that there is a tendency towards enhanced disclosure today on a routine basis in clinical practice and that, in many cases, the responsible body of professional practice is likely to favour broader disclosure.³

20.12.2 Further guidance as to disclosure of information

Foreseeability of risks

The doctor owes the patient a duty of care in explaining the “inherent implications” of the particular treatment. There is insufficient judicial guidance as to which risks must be disclosed. However, the responsibility to give information arises from the overall duty to exercise reasonable care in the treatment of the patient; it follows that the

¹ M. Jones, “Informed Consent and other fairy stories” [1999] 7 *Medical Law Review* 103 at p. 118.

² See Grubb, *supra*, at p. 64.

³ See, for example, General Medical Council guidance “Seeking patients’ consent: the ethical considerations”, GMC, London, February 1999.

risks which must be disclosed would be those that were reasonably foreseeable. There is no duty to disclose minimal or remote risks attendant to a medical procedure,¹ particularly where the treatment is necessary or non-elective—*i.e.* there is no other course open to the patient which would provide him with a chance of recovery. In *Bolam v. Friern Hospital Management Committee* a voluntary patient was given electro-convulsive therapy without modification (*i.e.* without anaesthetic or muscle relaxant) and he sustained serious fractures; he had not been informed of this risk. McNair, J. directed the jury that: “. . . when a doctor was dealing with a mentally sick man and had a strong belief that his only hope of cure was submission to electro-convulsive therapy, the doctor could not be criticised if, believing the dangers involved in the treatment were minimal, he did not stress them to the patient.”²

Psychological harm or distress to the patient

There is good authority for suggesting that a reasonable doctor, in deciding whether to disclose a risk, can take into account the serious psychological harm or distress to the patient if he were made aware of the possibility of the risk.³ It is suggested that failure to disclose a **remote** risk in order to “prevent unnecessary worry for the patient” may be reasonable. However, it would not be consistent with the doctor’s general duty of care to fail to disclose a clearly **foreseeable** risk because of the concern that, if the risk were disclosed, the patient would not consent to the treatment; this would improperly substitute the doctor’s judgement of “best interests” for that of the patient.

The therapeutic/non therapeutic distinction

A stronger case for full disclosure of information can be made if the medical procedure is non-therapeutic because the patient has a real choice whether to give consent. In *Gold v Haringey Health Authority*⁴ the sterilisation the patient received was not medically necessary. See further para 20.09 above. Nevertheless, the Court of Appeal would not depart from the *Bolam* rule. The court rejected the therapeutic/non-therapeutic distinction as “elusive”.⁵ Thus, if a substantial body of

¹ See *Bolam v. Friern H.M.C.* [1957] 1 W.L.R. 582, 2 All E.R. 118; *O’Malley-Williams v. Board of Governors of the National Hospital for Nervous Diseases* [1975] 1 B.M.J. 635 (failure to warn patient who underwent an aortogram of remote risk of partial paralysis was not negligent where patient had not himself raised the question with the doctor). The Canadian courts have gone further. See *Hopp v. Lepp* (1980) 112 D.L.R. (3d.) 67 at 81. (A “material risk” is not only one which is foreseeable but even one which is a “mere possibility” (which ordinarily need not be disclosed) if it carries serious consequences). Followed in *Reibl v. Hughes* (1980) 114 D.L.R. (3d.) 1.

² [1957] 1 W.L.R. 582, at 590.

³ See *O’Malley* [1975] 1 B.M.J. 635; *Bolam* [1957] 1 W.L.R. 582; *Hatcher v. Black*, *The Times*, July 2, 1954 (information before an operation is given need not include risks if the doctor merely prevaricated to stop the patient from unnecessary worry). *Sidaway*, per Lord Scarman, *Times Law Report*, Feb. 22, 1985.

⁴ [1987] 2 All E.R. 888.

⁵ [1987] 2 All ER at 894. Stephen Brown LJ states that a distinction between ‘therapeutic’ and ‘non-therapeutic’ treatment is “wholly unwarranted and artificial”, at 896.

responsible doctors would not have warned of the risk of failure of the sterilisation operation, the health authority was not liable in negligence.

Requesting information

There is a body of caselaw which suggests that where the patient specifically asks for information regarding the risks or potential adverse effects of a medical procedure, the doctor must answer truthfully; the doctor is under a duty to use due care in replying to questions put to him by the patient.¹

The doctor's duty to answer a patient's request for information truthfully was discussed in *obiter* by the Court of Appeal in *Blyth v Bloomsbury Health Authority*² Kerr LJ distinguished between general and specific requests for information. He suggested that a general request was similar to no request at all; and even where a request for specific information was made there "may always be grey areas". It "must depend on the circumstances, the nature of the enquiry, the nature of the information which was available, its reliability, relevance and the like".

It is suggested that, despite the holding in *Blyth*, trust in the doctor/patient relationship requires that all of the patient's reasonable questions are answered fully and honestly. In *Sidaway* even Lords Diplock and Bridge said that where information was requested "the doctor would tell him whatever it was the patient wanted to know"³ Indeed, if the doctor's answer was badly misleading, it could vitiate the patient's consent entirely.⁴

Causation

In a claim based upon negligence, causation must be established. Thus, the patient would have to establish that, as an ordinary reasonable person, he would not have consented to the treatment if he had been apprised of the risks and adverse effects.⁵ Moreover, were the patient to seek damages, he would have to show that his injury was caused by the doctor's lack of due care. In *Wilsher v. Essex Area Health Authority*⁶ the House of Lords felt that where a patient's injury is

¹ See *Smith v. Auckland Hospital Board* [1965] N.Z.L.R. 191. The New Zealand Court of Appeal applied the principle set in *Hedley Byrne & Co. Ltd. v. Heller and Partners Ltd* [1964] A.C. 465 and took into account Lord Denning's summing up in *Hacher*. See *Hopp V. Lepp* (1980) 112 D.L.R. (3d.) 67, at 81. See also *Thake v. Maurice* [1986] 1 All E.R. 497, C.A. (Patient not informed that sterilisation can be reversible by natural recanalisation, and became pregnant. Held, that a surgeon does not warrant a particular result, but failure to warn that an operation might, rarely, fail amounted to negligence.)

² *The Times*, February 11, 1987.

³ [1985] 1 All E.R. 643; p. 659 per Lord Diplock; p. 661 per Lord Bridge.

⁴ See *Freeman v Home Office* [1984] 1 All E.R. 1036, 1044. See also Montgomery, Power/Knowledge/Consent; Medical Decisionmaking, *Mod L. Rev.* Vol 51, p. 245 at 248.

⁵ *Bolam v. Friern H.M.C.* [1957] 1 W.L.R. at 590 ("if a warning had been given would it have made any difference?"); *Chatterton v. Gerson* [1981] 1 All E.R. at 267. See *Reibl v. Hughes* (1980) 114 D.L.R. (3d.) 1, at 35.

⁶ [1988] 1 All E.R. 871. See Boon (1988) Causation and the Increase of Risk, *Mod. L. Rev.* Vol 51, p. 508.

attributable to a number of possible causes one of which is the doctor's negligence, the combination of the doctor's breach of duty and the patient's injury does not give rise to a presumption that the doctor caused the injury. Instead, the burden remains on the patient to prove the causative link between the negligence and the injury, although that link could legitimately be inferred from the evidence.¹

20.13 Voluntariness

A person consenting to a medical procedure must do so voluntarily. (See para. 21.05.2 *post*). Consent is vitiated if it is given by coercion, fraud or a show of authority. Lord Donaldson MR in *Re T (Adult: Refusal of Treatment)*² stated that, while it is acceptable for the patient to receive advice and even strong persuasion in reaching a treatment decision, the persuasion cannot "overbear the independence of the patient's decision." "The real question is 'Does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself.' In other words, 'Is it a decision expressed in form only, not in reality?'"

Lord Donaldson enunciated two criteria in considering the effects of outside influences: the strength and will of the patient; and the relationship of the "persuader" to the patient. The more vulnerable, or the weaker the will, of the patient the less influence she may be able to sustain. At the same time, persuasion of close relatives, particularly on the basis of religious convictions, are likely to be stronger and more influential.

A patient should not be threatened with compulsory admission if he refuses consent, for this could undermine the free choice of the patient. However, if the patient's condition actually came within the statutory criteria for compulsory admission the consent to treatment might be valid. The fact that the patient is subject to institutional pressures does not in itself mean that he cannot give consent of his own free will. In *Freeman v. Home Office*, McCowan, J. said 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 of what may appear, on the face of it, to be a real consent is not in fact so".³ This is probably the approach the courts would take in the case of a patient in a mental hospital.

¹ See further *Kay v. Ayrshire and Arran Health Board* [1987] 2 All E.R. 417 (where two competing causes of damage existed the law could not presume that the tortious cause was responsible for the damage if it was not first proved that it was an accepted fact that the tortious cause was capable of causing or aggravating such damage). *Hoson v. East Berkshire AHA* [1987] 2 All E.R. 909, H.L. (crucial question of fact was whether the cause of the patient's injury was his fall or the health authority's negligence, since if the fall caused the injury the negligence was irrelevant).

² [1993] Fam 95, [1992] 4 All E.R. 649, [1992] 3 W.L.R. 782.

³ [1983] 3 All E.R. 589 at 597, passage approved on appeal, [1984] 1 All E.R. 1036, at 1043, 1045.

20.14 Specificity

Consent must be to the actual act performed. When a patient consents to a medical procedure, it would include authorisation to do whatever is normally and reasonably done in connection with that procedure. Consent to electro-convulsive therapy, for example, would reasonably provide authorisation for the imposition of an anaesthetic and muscle relaxant. Further, consent would be for a course of such treatments in accordance with established medical practice, although consent could be retracted at any time. The consent, however, could not authorise future courses of ECT. Specificity, then, requires the treatment to be as closely related as reasonably possible to that which the patient has consented.

20.15 Competency

The patient must be competent to give consent to the proposed treatment. Every adult is presumed to have the competency to make treatment decisions, but that presumption is rebuttable. Lord Donaldson in *Re T (Adult: Refusal of Treatment)*¹ surveyed the various manifestations of incompetency—both short and longer-term:

[A] small minority of the population lack the necessary mental capacity due to mental illness or retarded development. . . . This is a permanent or at least a long-term state. Others who would normally have that capacity may be deprived of it or have it reduced by reason of temporary factors, such as unconsciousness or confusion or other effects of shock, severe fatigue, pain or drugs being used in their treatment. . . . What matters is that the doctors should consider whether at that time [the time of the decision] he had a capacity which was commensurate with the gravity of the decision which he purported to make.

Competency is a complex concept that can rarely be stated in categorical or absolute terms. A person's capacity to comprehend the nature and purpose of the treatment may vary over time and may depend on all the circumstances. A person may be competent for some purposes and at certain times, but incompetent at others. Moreover, competency is not an objective scientific term that can be measured with precision. Identifying the level of understanding requires rigorous medical and lay assessment and can be made only in shades of gray.

The entire foundation of the law of consent is based upon the competency of the patient. Yet, the standard has seldom been articulated by the courts.² Thorpe J, in upholding the right of a patient with chronic paranoid schizophrenia to refuse a leg amputation, framed the competency issue as follows: is the patient's "capacity so reduced by his chronic mental illness that he does not sufficiently understand the nature, pur-

¹ [1993] Fam 95, [1992] 4 All E.R. 649, [1992] 3 W.L.R. 782.

² See informative judgment of Linden J in *White et al. v. Turner et al.* (1981) 120 D.L.R. (3d) 269; The Law Commission, *Mentally Incapacitated Adults and Decision-Making: An Overview* (London: HMSO, 1991). As to the various tests for competency that could be adopted see Roth, Meisel & Lidz (1977) *Tests of Competency to Consent to Treatment*, *Am. J. Psychiat.*, vol. 134, p. 279.

pose and effects of the treatment he refuses.”¹ Thorpe J broke the decision-making process into three stages for the purposes of assessing competency: “first, comprehending and retaining treatment information, secondly, believing it and, thirdly, weighing it in the balance to arrive at choice.” He found that the patient “understood and retained the relevant treatment information, that in his own way he believes it, and that in the same fashion he has arrived at a clear choice.”

Butler-Sloss LJ in *Re MB*² reasoned that a person lacks capacity if some impairment or disturbance of mental functioning renders him unable to make a decision whether to consent or to refuse treatment. The inability to decide occurs when: (a) the person is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequence of having or not having the treatment; or (b) the person is unable to use the information and weigh it in the balance as part of the process of arriving at the decision (e.g., a person with a compulsive disorder or phobia may not believe the information presented to her or may focus so intently on one piece of information to the exclusion of other relevant factors).³ Irrationality (in the sense that the decision is outrageous—in defiance of logic or of accepted moral standards), panic, and indecisiveness in themselves do not amount to incompetence, but they may be symptoms or evidence of it.

The treatment decisions of a competent adult must be respected. Neither the medical profession nor the judiciary may substitute their judgment for that of a competent adult. It does not matter that others disagree with the patient’s reasons or that it would not be in his best interests.⁴ But what is the legal position if the patient is determined to be incompetent? A strict construction of the law of battery suggests that the doctor would be liable in the absence of consent or some other justification. Accordingly, substituted consent by a legally appointed guardian or a declaration by the court could be thought to be required prior to treating an incompetent patient. However, except for certain serious treatments,⁵ the courts have found that doctors should treat

¹ *Re C (Refusal of Medical Treatment)* [1994] 1 All E.R. 819, [1994] 1 W.L.R. 290, [1994] 1 F.L.R. 31. See *Secretary of State for the Home Department v. Robb* [1995] 1 All E.R. 677, 1 F.C.R. 577, 1 F.L.R. 412, Family Division, 4 October 1994.

² *The Independent* 8 April 1997, *The Times* 8 April 1997 (Transcript: Smith Bernal), C.A. (Civil Division). See *Norfolk and Norwich Healthcare (NHS) Trust v. W.*, 34 BMLR 16, [1996] 2 FLR 613, [1997] Fam Law 17, [1997] 1 FCR 269 (Family Division). See also section 20.19 *post*.

³ See also the similar recommendations of the Law Commission. *Mental Incapacity*, paras 3.2–3.23 (No. 231, 1995).

⁴ *Airedale NHS Trust v. Bland* [1993] A.C. 789, 1 All E.R. 821, [1993] W.L.R. 316, [1993] 1 F.L.R. 1026.

⁵ For example, in a Practice Note, the High Court announced that the prior sanction of a High Court judge is required in virtually all cases of termination of artificial feeding and hydration of individuals in a persistent vegetative state. The applications should follow the procedure laid down for sterilisation cases in *F. v. West Berkshire Health Authority* (see 20.15B.2). High Court [1994] 2 All E.R. 413, 1 F.L.R. 654, 18 B.M.L.R. 159, 1 March 1994.

patients in their best interests after determining that they lack the necessary capacity to consent.¹

20.15A Competency of Minors

In deciding upon the right of a **minor** to consent to treatment, the court will not look to a fixed age, but will look instead at maturity and the degree of intelligence and understanding of the minor. The court considers the staged development of the child. Competency in a minor may even rise to a higher level of understanding than for an adult, requiring “a full understanding and appreciation of the consequences both of the treatment in terms of intended and possible side effects and, equally important, the anticipated consequences of a failure to treat.” This standard of competency was referred to by the Court of Appeal in *Re R (A Minor)*² as “Gillick competence.”³ However, the court provided no explanation of whether “Gillick competence” for minors differed from competency determinations for adults and, if so, why.

20.15A.1 *Minors aged sixteen or older*

The Family Law Reform Act 1969 provides that the consent of a minor who has attained the age of sixteen to medical or dental treatment which, in the absence of consent would constitute a trespass to the person, is effective as if the minor were of full age.⁴ Thus, insofar as consent to medical treatment (including psychiatric treatment) is concerned, a person aged sixteen or older is in the same legal position as an adult. However, in *Re W (a minor) (medical treatment)*⁵ the Court of Appeal took the view that although s. 8 of the 1969 Act gave minors who have attained the age of 16 the right to consent to treatment, it did not confer on them an absolute right to refuse. The High Court, exercising its inherent jurisdiction, could override the refusal if it was in the child’s best interests to do so. A doctor could proceed to treat with parental consent or from the local authority where the local authority has parental powers, even though the 16 or 17-year-old him or herself refused. All three judges emphasised that although such juveniles could not make a binding decision, their refusal could be a very important factor to be taken into account by doctors in making clinical judgments, and for the court and parents in deciding whether to give consent.

20.15A.2 *Minors under the age of sixteen*

The Family Law Reform Act 1969 does not revoke any common law right of a minor below the age of sixteen to consent on

¹ *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, [1992] 4 All E.R. 649, [1992] 3 W.L.R. 782. See *Norfolk and Norwich Healthcare (NHS) Trust v. W*, 34 BMLR 16, [1996] 2 FLR 613, [1997] Fam Law 17, [1997] 1 FCR 269 (Family Division). See also section 20.19 *post*.

² [1992] Fam. 11; [1991] 3 WLR 592.

³ *Gillick v. West Norfolk AHA* [1986] 1 A.C. 112 is discussed below.

⁴ Family Law Reform Act 1969, s. 8. The age of a majority is eighteen (s. 1).

⁵ [1992] 4 All ER 627, (1992) 9 BMLR 22.

his own behalf. Minors who are capable of understanding the nature and purpose of medical treatment can provide legally effective consent. In *Gillick v. West Norfolk AHA*¹ the House of Lords found that Department of Health advice in HN(80)44 that doctors may provide contraception for minors under sixteen, without parental knowledge and consent, was not unlawful. The House of Lords held that a minor under the age of sixteen years has the legal capacity to consent to medical examination and treatment, including contraceptive treatment, if she has sufficient maturity and intelligence to understand the nature and implications of the proposed treatment. The parental right to control a minor deriving from the parental duty is a dwindling right which exists only so far as the minor does not have the competence to determine for herself what treatment is appropriate for her benefit and protection.

In deciding upon the right of a minor to consent to treatment, the court will not look to a fixed age, but upon maturity, degree of intelligence and understanding of the minor.

The parental right to determine what is in the best interest of the minor, and to consent to medical treatment on her behalf, diminishes as she achieves greater understanding to make that decision herself. Lord Scarman, in *Gillick*, made his this point plainly: "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 a sufficient understanding and intelligence to enable him or her to understand fully what is proposed . . . The underlying principle of the law was exposed by Blackstone and can be seen to have been acknowledged in the case law. It is that the parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision."

It is important to note that the *Gillick* case involved a hypothetical situation where the minor was **seeking** medical treatment which was accepted by a respectable body of medical opinion. If the medical decision to be made by the minor is for her welfare (*i.e.*, to improve her mental or physical health) and is one which a doctor acting in accordance with established medical practice agrees with, then it is not for the parents or guardian to substitute their judgement for that of the mature minor.

The Code of Practice (para. 30.7) concurs with this position. If a child under sixteen has "sufficient understanding and intelligence", he can take decisions about his own medical treatment in the same way as an adult. If the minor is not competent the permission of the parent, guardian, or care authority (whichever has lawful authority) is required. If parents/guardians unreasonably withhold permission, consideration should be given to the use of child care and/or mental health legislation. Wardship may be appropriate if the child's best interests are at stake.

¹ [1986] 1 A.C. 112; [1985] 3 W.L.R. 830.

If the child is a ward of the court, the High Court must give consent for treatment. The child's parents should be consulted.

Lord Donaldson M.R. in *Re R (A Minor)*¹ took issue with Lord Scarman's *dictum* in *Gillick* suggesting that competent minors had the right to **refuse** medical treatment which their parents wanted them to have. At least two High Courts cases had found that a "*Gillick* competent" minor had a right to refuse treatment.²

Re R (A Minor) involved a fifteen year old woman who was refusing anti-psychotic medication. The treatment centre which was suitable to care for her would not accept her unless she consented to the medication or the court authorised the medication. Wardship proceedings were brought to seek authority of the court to treat her without her consent. Lord Donaldson concluded that: (1) No doctor can be required to treat a minor, whether by the parents, the minor, or the court in the exercise of its wardship jurisdiction. The decision to treat is a matter of professional judgement subject to the consent of someone who has the authority to consent (except in an emergency); (2) A competent minor, the parents or guardian, and the court all have a concurrent power to consent. *Any* one body or person has the power to provide legally effective consent with no one person having a veto; (3) A competent minor has the power to consent, but this is concurrent with a parent or guardian; (4) "*Gillick*-competence" is a developmental concept and is not lost or acquired on a day to day or week to week basis. In the case of mental disability, that disability must also be taken into account, particularly where the person has fluctuating competence. In *Re R (A Minor)*, the fact that the young woman had moments of lucidity did not render her "*Gillick*-competent" if she foreseeably might lose that competence and decline needed treatment; (5) The court in the exercise of wardship jurisdiction has the power to override the decisions even of a fully competent minor if it is in her best interests. The Court of Appeal found the young woman not to be competent and that the court, in any case, could have required treatment in her best interests.

Re R reliably stands for the proposition that either the parents or the court can consent to treatment over the objections of an **incompetent** minor. The court acting in *parens patriae* can also consent to the treatment of a **competent** minor if the treatment clearly is in her best interests.

Lord Donaldson's *dicta* that a parent or guardian could override a competent patient's refusal to be treated was neither supported nor rejected by the other two members of the Court of Appeal in *Re R (A*

¹ [1992] Fam 11; [1992] 3 WLR 592.

² *Re R (A Minor)*, Waite, J, July 9, 1991; *Re E*, Ward J, September 21, 1990 (a 15-year old boy who had religious objections, that were supported by his parents, to being given a life-saving blood transfusion). Both cases accepted that *Gillick* applied as much to a situation in which the competent minor was refusing consent. But in both cases, the High Court found the minor was not "*Gillick*-competent."

Minor) (Staughton LJ and Farquharson LJ). That dicta also flies in the face of Lord Scarman's statement in *Gillick*. Clarification by the judicial House of Lords or Parliament of the right of a competent minor to reject unwanted treatment is supremely important. Lord Donaldson supported his position by referring to the unfairness to the doctor who, relying on either the parent or minor, could then be sued for failure of the other to consent. Reliance on the malpractice risks of doctors, while important, is not a sufficient foundation upon which to base a decision to override the competent refusal of a mature minor. Rather, such judgements should be based upon the right to self-determination of a competent patient, and her right to decide for herself what treatment she is to receive. It would be inappropriate, for example, for an abortion to be performed on a young competent woman against her will based upon her mother's consent.¹ Medical treatment is personal and fundamental to an individual's sense of self-identity and dignity. If competent minors were unequivocally given the right to refuse medical treatment, the court, nevertheless, could exercise its *parens patriae* powers to require treatment. In such cases, the minor would receive the safeguard of a judicial hearing based upon the objective standard of her best interests.

Despite these concerns, the Family Division in *Re K, W and H (Minors)*² applied the decision in *Re R* in a case involving two 15-year-olds and one 14-year-old all held to be non-"Gillick competent." The parents of the minors all consented in advance to the use of emergency medication in the event the minors became "self destructive or violently combative." Each of the minors refused to consent to treatment. Thorpe J cited *Re R* for the proposition that a child with Gillick competence can consent to treatment but if he or she declines to do so, consent can be given by the parent. "Where more than one person has the power to consent, only a refusal of all having the power will create a veto." In this case the parental consent would have made the treatment lawful. The court never addressed the question whether a "blanket" consent given for all children at the time of admission was legally effective consent.

20.15B Substituted or Proxy Consent for Incompetent Minors

The patient (whether an adult or a minor) must be capable of providing legally effective consent to the proposed treatment. If a

¹ See *Re P (A Minor)* [1986] 1 F.L.R. 272, 80 L.G.R. 301 (the girl's own wishes, the danger of injury to her mental health and to the welfare of her current child, and the loss of social and educational opportunities, led to the conclusion that continuation of the pregnancy posed a much greater risk than the risk of abortion). See also *Re B (A Minor)* *The Times* 27 May 1991 (Mother sought abortion for minor child despite child's wish for termination of pregnancy. Hollis J held that the abortion was in minor's best interests).

² [1993] 1 F.C.R. 240 (Transcript: Carter Walsh).

person is temporarily or permanently incompetent, her consent will not be regarded as a defence in an action in battery. In these circumstances the doctor must either obtain a substitute or proxy consent by a person or body legally empowered to provide that consent or the doctor must have a justification such as a medical emergency or other condition of necessity, for treating in the absence of consent.

Legally effective substituted consent can be provided for an incompetent **minor** only by a parent, a legal guardian, or a court. The court has jurisdiction based upon its *parens patriae* powers to make a minor a ward of court if it is in her best interests. Accordingly, the court can order any beneficial treatment to be provided to the ward. Once a minor is a ward of court, no major treatment should be given without permission of the court.¹

It has been held that “a child who is a ward of court should be treated medically in exactly the same way as one who is not, the only difference being that the doctor will be looking to the court rather than the parents for any necessary consents.”² It is clear, however, that the “practical jurisdiction of the court is wider than that of the parents.”³ For example, it is clear that the court can order beneficial treatment, even over the ward’s objection.⁴

20.15B.1 *Withdrawal of life sustaining treatment for severely handicapped minors*

What criteria should the parents or courts use to assess the best interests of severely handicapped children, such as those who are terminally ill, in a persistent vegetative state, or cannot interact, even minimally, with their environment?⁵ Courts adopt a firm, but rebuttable, presumption in favour of life sustaining treatment, irrespective of the child’s future quality of life. Thus, in *Re B (A Minor) (Wardship: Medical Treatment)*⁶ the Court of Appeal ordered treatment for an intestinal blockage for a child with Down’s Syndrome. The Court held that consent to life sustaining treatment could be withheld only if the child’s quality of life would be “intolerable” to the child, “bound to be

¹ *Re G-U (A Minor) (Wardship)* [1984] FLR 811. (When a child is a ward of court, even if she is in the care of a local authority, no major step in the ward’s life may be taken without the approval of the court. The paramount standard for proxy consent by the court or parent is the best interests of the minor.) As to a wardship, see further para. 24.33 post.

² *Re J (A Minor) (Wardship: Medical Treatment)* [1990] 3 All E.R. 930, Donaldson MR.

³ *Re R (A Minor)* [1992] Fam. 11; [1991] 3 WLR 592.

⁴ *Ibid.*

⁵ See Gostin L (1986) A Moment in Human Development: Legal Protection, Ethical Standards and Social Policy on the Selective Non-Treatment of Handicapped Neonates, *Amer. J. Law & Med.*, vol 11, pp. 31–78.

⁶ [1990] 3 All ER 927, [1981] 1 W.L.R. 1421.

so full of pain and suffering” and “demonstrably . . . so awful that in effect the child must be condemned to die.”¹

The courts, however, will not prolong the life of a child needlessly if he is terminally ill. In *Re C (A Minor) (Wardship: Medical Treatment)*² the Court of Appeal held that treatment would be authorised to relieve the suffering of a terminally ill child, but that it would accept medical opinions to provide only nursing care rather than aggressive treatment to achieve a short prolongation of life.

*Re J (A Minor) (Wardship: Medical Treatment)*³ involved a child who was neither terminally ill, as in *Re C*, nor did he have a normal lifespan, as in *Re B*. *Re J* concerned a premature infant who was likely to develop spastic quadriplegia, have severely impaired vision and hearing, and develop highly limited intellectual capabilities so that he could not speak. The infant could experience pain. The Court of Appeal held that the infant should be treated with antibiotics if he developed a chest infection, but should not be ventilated if his breathing stopped unless his doctors deemed it clinically appropriate. The Court adopted a balancing test that should be used to determine the child’s best interests. Courts should have regard to: (i) the child’s point of view, giving the fullest possible weight to his desire, were he in a position to make a sound judgement, to survive (the presumption in favour of prolonging life is powerful but not irrebuttable); (ii) the pain and suffering and the quality of life he would experience if life were prolonged; and (iii) the invasiveness, risks, and pain and suffering involved in the proposed treatment itself.

The Court of Appeal said that the sanctity of life is important, but it rejected an absolutist approach. The Court of Appeal applied a substitute judgement standard.⁴ The court should put itself in the position of the patient and make the judgement the patient would if he were competent and in position to do so. This gives effect to the heavy presumption favouring life: “even very severely handicapped people find quality of life rewarding which the unhandicapped may seem manifestly intolerable. People have an amazing adaptability.”⁵ But, rarely, the child’s interests will not be furthered by subjecting him to treatment which will cause increased suffering and no commensurate benefit.

The Court of Appeal emphasised in dictum that the authority of doctors, parents, and even the courts is limited to providing or with-

¹ *Re B (A Minor)* [1990] 3 All E.R. at 929, 930.

² [1989] 2 All ER 782, [1989] 3 W.L.R. 240. The Court of Appeal also issued an injunction prohibiting identification of the ward, the parents and the hospital. *Re C (a minor) (Wardship: Medical Treatment) (No. 2)* [1989] 2 All E.R. 791.

³ [1990] 3 All E.R. 930, [1990] 2 W.L.R. 140.

⁴ See *In re Weberlist* (1974) 260 NYS 2d 783, at 787, quoted in *re Superintendent of Family and Child Service and Dawson* (1983) 145 DLR (3d) 610, and in *Re C sub nom Re SD* [1983] 3 WWR 618.

⁵ *Re J (a minor) (Wardship: Medical Treatment)* [1990] 3 All E.R. 930, Donaldson MR.

holding standard medical treatment. No one had the authority to take affirmative means to hasten death. There is no support in English law for doctor assisted suicide or euthanasia.¹

The 1992 case of *Re J (a minor) (wardship: medical treatment)*² involved a profoundly disabled 16 month old baby with a very short life expectancy. The consultant paediatrician at the hospital considered that whilst it would be appropriate to offer ordinary resuscitation, it would not be medically appropriate to intervene with intensive measures such as artificial ventilation. An order had been sought requiring the health authority to provide all available treatment to J, including intensive resuscitation. The Court of Appeal held that the court would not exercise its inherent jurisdiction to protect the interests of minors to order a medical practitioner, or a health authority acting by a medical practitioner, to adopt a course of treatment which in the bona fide clinical judgment of the doctor concerned was contraindicated as not being in the best interests of the patient.

20.15B.2 Sterilisation of minors

In *Re B (A Minor) (Wardship: Sterilisation)*,³ the House of Lords held that because of the seriousness of performing a non-therapeutic⁴ sterilisation on a severely mentally handicapped minor, the High Court, Family Division, must give prior approval. In deciding whether to give prior approval the court would exercise its wardship jurisdiction. The Lords reiterated the established common law principle that, under the court's *parens patriae* powers, the best interests of the minor is the only consideration in wardship proceedings.⁵

B. was seventeen years of age and in the care of the Sutherland Borough Council. The Council applied by originating summons to the Family Division of the High Court for an order making the minor a ward of the court and for leave for her to be sterilised by occlusion of the fallopian tubes. The court found her to be "moderately" mentally handicapped with intellectual development limited to a six year old. She was found not capable of: a long-term relationship or of rearing a child; understanding the association between sexual intercourse and pregnancy; understanding the need for contraception; and giving consent or making an informed choice about contraception or a caesarean section should that be required. Paradoxically, she was found

¹ See also *R. v. Cox* (1992) 12 BMLR 38 and *Airedale NHS Trust v. Bland* [1993] 2 WLR 316; [1993] 1 All ER 821.

² [1993] Fam 15; [1992] 3 WLR 507; [1992] 4 All ER 614.

³ [1988] 1 AC 199, [1987] 2 All E.R. 206, [1987] 2 W.L.R. 1213, [1987] FLR 314.

⁴ In *Re E (A Minor)* (1991) 7 BMLR 117, Sir Stephen Brown held that the consent of the court is **not** required for a **therapeutic** sterilisation. In such cases, the parent could give consent on behalf of the minor. In that case a 17 year old mentally handicapped woman required a hysterectomy for therapeutic purposes, but with the inevitable consequence of sterilisation.

⁵ See *Wellesley v. Wellesley* (1828) 2 Bli. N.S. 124, 4 E.R. 1078.

capable of reasonable hygiene in relation to menstruation and of understanding the link between pregnancy and a baby. It was unclear why she could not have received effective educational training and support to increase her understanding and ability to cope.

The House of Lords in *Re B* held that sterilisation was the only reasonable alternative to effectuate her best interest in preventing pregnancy. Barrier contraception was ruled out because of its ineffectiveness; and oral contraception was ruled out because of the risk to her health and the probability that she would not reliably take it.

The narrow holding of the House of Lords in *Re B* can be summarised as follows. Reproduction is a “fundamental” human right which can be overridden only by an “overwhelming case” showing that sterilisation is in the ward’s best interests. Considerations of society, eugenics, public policy, and the convenience or anxiety of those who care for the ward are irrelevant. Sterilisation, moreover, can be performed on a ward only as a “last resort”. Thus, if there are methods of contraception which can be achieved with less intrusion or permanency, they are to be preferred.

The House of Lords in *Re B* supported the decision of Heilbron, J., in *Re D (A Minor)*¹ who accepted wardship in the case of a girl aged eleven with Sotos Syndrome (a rare hereditary condition). The court refused to allow a sterilisation which had been arranged with the consent of the parent. It reasoned that the operation proposed involved a deprivation of a basic human right which required consent. Since the minor could not give legally effective consent, but there was a strong likelihood she would understand the implications by age 18, the case was one in which the courts should exercise its protective powers.

If parents or staff propose to sterilise a severely mentally handicapped minor a clear procedure has to be followed. First, because of the seriousness of deciding whether a minor should be sterilised, the High Court, Family Division, would have to give prior approval. Second, in deciding whether to give prior approval, the court would exercise its wardship jurisdiction and, in doing so, would use the best interests of the minor as the paramount consideration. Third, the wardship jurisdiction of the court would be invoked through the issue by an interested party of an originating summons under R.S.C., Ord. 90, r. 3. The procedure then followed is designed to bring all relevant expert and other evidence before the court.²

The Official Solicitor has issued a Practice Note concerning applications to the High Court for sterilisation.³

In virtually all cases, the sterilisation of a minor will require the prior

¹ [1976] Fam. 185, [1976] 1 All E.R. 326, [1976] 2 W.L.R. 279.

² *F. v. West Berkshire Health Authority* [1990] 2 A.C. 1 H.L., per Lord Brandon.

³ Practice Note (Official Solicitor: Sterilisation) [1993] 3 All E.R. 222; [1993] 2 FLR 222; (1993) 16 BMLR 60. This replaces the Practice Note issued in 1990 ([1990] 2 FLR 530).

sanction of a High Court judge.¹ Applications in respect of a minor should be made in the Family Division within proceedings either under the inherent jurisdiction or section 8(1) (specific issue order) of the Children Act 1989. In the Official Solicitor's view, the procedural and administrative difficulties with applications under s. 8 of the 1989 Act are such that the preferred course is to apply within the inherent jurisdiction. The applicant should normally be a parent or one of those responsible for the care of the patient or intending to carry out the proposed operation. The patient must always be a party and should normally be a defendant or respondent. Where the patient is a defendant or respondent, the guardian ad litem should normally be the Official Solicitor. The Official Solicitor will act as either an independent and disinterested guardian representing the interests of the patient, or as ex officio defendant, who will carry out his own investigations, call his own witnesses, and take whatever other steps are necessary to ensure that all relevant matters are thoroughly aired before the judge. The purpose of the proceedings is to establish whether or not the proposed sterilisation is in the best interests of the patient. The judge will require to be satisfied that those proposing sterilisation are seeking it in good faith and that their paramount concern is for the best interests of the patient rather than their own or the public's convenience. The proceedings will normally involve a thorough adversarial investigation of all possible viewpoints and any alternatives to sterilisation. Nevertheless, straightforward cases proceeding without dissent may be disposed of at the preliminary hearing for directions held before a High Court judge of the Family Division which will take place in every case. The Practice Note also outlines the type of evidence which the official solicitor anticipates that judges will expect regarding present and future decision-making capacity, that the operation is necessary, that the patient will experience substantial trauma if the event which the operation is designed to avoid takes place, and that there is no practicable less intrusive alternative means of solving the problem. The Practice Note is intended as guidance, not as a mandatory code.²

20.16 Necessity: Treatment of Adults in the Absence of Consent

A doctor will, in certain circumstances, be justified in providing treatment or in medically or physically restraining a person (see further para. 21.06 *post*) without consent.³ The legal ground upon which such

¹ See however *Re E (a minor)* [1991] 2 FLR; (1991) 7 BMLR 117, where the court ruled that when a hysterectomy is sought for strictly therapeutic reasons and not to achieve sterilisation, it is not necessary to apply to the court for approval. In that case the consent of the parents of a 17-year-old girl was sufficient.

² *J v. C* (1990) 5 BMLR 100. This case concerned the 1990 Practice Note ([1990] 2 FLR 530) which has been replaced by the 1993 version.

³ See P. Skegg (1974) A Justification for Medical Procedures Performed without Consent, *L.Q.R.*, vol. 90, pp. 512-530. See also G. Williams (1978) Defences of General Application: Necessity, *Crim. L. Rev.*, 128; I. Kennedy (1976) The Legal Effect of Requests by the Terminally Ill and Aged not to Receive Further Treatment from Doctors, *Crim. L. Rev.* 217.

a justification is normally based is the agency of necessity,¹ but the language of consent has also been used; consent in certain circumstances is “implied” or “presumed” or can be assumed will be obtained in “future”. The justification is not subject to tidy or definitive legal characterisation, but is merely a number of disparate judicial responses to specific factual circumstances. Plainly, a life saving medical procedure may be performed where a person cannot provide the requisite consent (e.g. by reason of unconsciousness) and is not known to object to the performance of the procedure.² There are, however, variations on this same set of facts where the application of the common law is less clear. If the patient, though now incompetent, was known to have an objection to the treatment, the preferred view is that the doctor would not be justified in proceeding. It is helpful to distinguish between short term and permanent incompetency. If the person’s incompetency is transient (e.g. from anaesthetic, sedation, intoxication or temporary unconsciousness) there would not be a justification for doing everything which the doctor judged was beneficial to the patient. The Canadian position would be likely to be adopted where treatments which are “necessary”, i.e. “unreasonable to postpone”, are distinguished from those which are merely “convenient”; the former may be performed where the patient is temporarily unable to give consent, while the latter may not.³ As a general principle, treatment which is given to a patient while temporarily incompetent should be the minimum amount necessary for his health; any treatment which could reasonably be postponed until the patient regained competency should not be given.

A much more difficult and important question arises as to the extent of the doctor’s powers and duties to treat a non-volitional or otherwise incompetent patient where there is no reasonable likelihood that the person will regain competency. This is a major problem within the mental health services for there are many informal patients who are incompetent to give consent to medical or psychiatric treatment needed for their health and wellbeing—for example, patients who are severely mentally ill, severely mentally handicapped or elderly and confused. Situations arise where highly vulnerable, isolated and withdrawn patients require beneficial medical treatment (such as the removal of a cataract) to which they cannot give consent. The doctor’s dilemma is that if he administers treatment which he believes to be in the patient’s best interests, he runs the risk of being liable for trespass to the person; but if the doctor withholds treatment he may be in breach of a duty of care owed to the patient.⁴

¹ For a thorough discussion of the doctrine of necessity see the judgment of Lord Goff in *F. v. West Berkshire Health Authority* [1990] 2 A.C. 1, H.L.

² Judicial authority is from a line of Canadian cases. *Marshall v. Curry* [1933] 3 D.L.R. 260; *Murray v. McMurchy* [1949] 2 D.L.R. 442; *Parmley v. Parmley and Yule* [1945] 4 D.L.R. 81; *Mulloy v. Hop Sang* (1935) 1 W.W.R. 714.

³ See cases cited in the preceding note.

⁴ *F. v. West Berkshire Health Authority* [1990] 2 A.C. 1, H.L., per Lord Bridge.

Mr. Justice Wood in *Re T, T. v. T and another*¹ drew attention to the paucity of statutory or common law principles in guiding the doctor about the treatment of incompetent patients. (See further para. 20.09 above and para. 20.16.2 below). Mr. Justice Wood and several commentators² called for clarification of the law by the Legislature or the judicial House of Lords. The House of Lords in two subsequent cases clarified the law regarding the treatment of mentally incompetent children and adults: *Re B. (A Minor)*³ (medical treatment of minors) and *F. v. West Berkshire Health Authority*⁴ (medical treatment of incompetent adults).

The House of Lords in *Re B (A Minor)*⁵ left open the question whether there is inherent jurisdiction under its *parens patriae* powers in the case of an incompetent **adult** to sanction a medical procedure. The House of Lords returned to this subject in *F. v. West Berkshire Health Authority*,⁵ which also concerned the sterilisation of a severely mentally handicapped woman. The House of Lords decided that there is no inherent *parens patriae* jurisdiction to approve or disapprove a medical procedure for an incompetent adult. However, the court could issue a declaration of the lawfulness of a medical procedure. It is lawful for a doctor to provide medical treatment to adults who are incompetent to consent, provided the treatment is in their best interests. The justification for treatment in the absence of consent is the public interest in ensuring that mentally incompetent persons receive the same quality of care and treatment as those who are competent to consent.

A treatment is in the incompetent person's best interests only if it is carried out in order to save his life, or ensure improvement, or prevent deterioration, in his physical or mental health. The standard by which this is judged is the *Bolam* test – viz, whether the treatment is recognized as safe and effective by a responsible body of professional medical opinion (see further para. 20.12.1 above). Lord Brandon's judgment (accepted by a plurality of the Court) prescribed a procedure and standards for the medical treatment of mentally incompetent adults, which are described in paras. 20.16.1–20.16.3 below.

20.16.1 *It is not strictly necessary to obtain prior judicial approval for medical treatment of incompetent patients*

The House of Lords held that it is not strictly necessary to obtain the prior approval of the court for the medical treatment of

¹ [1988] Fam. 62, per Wood J.

² Chatterton DA, The powers of the courts in respect of the mentally handicapped, *Law Society Gazette*, p. 2441, Sept. 2, 1987. See also, *Law Commission Working Paper No. 101*, April 1987 on Wards of Courts.

³ [1987] 2 All E. R. 206, [1988] A.C. 199.

⁴ [1990] 2 A.C. 1.

⁵ [1988] A. C. 199.

incompetent persons.¹ The House of Lords arrived at this conclusion because no court has any jurisdiction over a mentally incompetent adult comparable with the wardship jurisdiction of the High Court over minors. Lord Brandon reviewed the *parens patriae* and statutory jurisdiction which the courts might exercise in these cases, and found each to be inapplicable. (See para. 20.16.2 below).

Sterilisation of Adults

However, in a case involving a serious and controversial treatment such as sterilisation, it is good practice to obtain a prior declaration by the court of its legality.² The reasons why it is desirable to obtain a prior judicial declaration of the lawfulness of sterilisation are set out in Lord Brandon's judgement: the procedure is irreversible; reproduction is a fundamental right of a woman; in the absence of judicial review there is a risk of a wrong decision or a decision taken for improper reasons or with improper motives; and a judicial declaration protects the doctors and others from subsequent criticism or legal liability. Lord Goff added that guidance of the High Court should be sought in order to obtain "an independent, objective and authoritative view on the lawfulness of the procedure . . . after a hearing at which it can be ensured that there is independent representation on behalf of the [incompetent] person."

For these reasons the United States,³ Australia⁴ and Canada have gone further than the House of Lords. Courts in the United States and in Australia have held that sterilisation of a woman lacking the capacity to consent can only be permitted with the court's approval.

The Canadian Supreme Court went further by ruling that sterilisation can never be lawful. In *Re Eve*⁵ La Forest, J. said:

"The grave intrusion on a person's rights and the certain physical damage that ensues from non-therapeutic sterilisation without consent, when compared with the highly questionable advantages

¹ Lord Griffiths dissented from this view: "I would myself declare that on grounds of public interest an operation to sterilise a woman incapable of giving consent either on grounds of age or mental incapacity is unlawful if performed without the consent of the High Court."

² The Official Solicitor has issued a Practice Note concerning applications to the High Court for sterilisation. Practice Note (Official Solicitor: Sterilisation) [1993] 3 All E.R. 222. The Practice Note is for the guidance of practitioners. It is not intended to be mandatory. *J. v. C.* (1990) 5 BMLR 100. Prior judicial approval, however, may not be necessary for a **therapeutic** sterilisation of an adult (*Re G.F.* [1992] F.L.R. 293) or of a minor (*Re E. (a Minor)* [1991] 2 F.L.R. 585). However, in a situation in which there is a dispute of medical evidence as to whether sterilisation is necessary or whether there is another effective alternative, the matter should be referred to the court for judicial determination. (*Re S.L. (Adult Patient)* [2000] 1 F.C.R. 361.)

³ See *In re Grady* (1981) 426 A2d 467.

⁴ See *In re Jane*, 85 A.L.R. 409, 22 December 1988.

⁵ [1986] 2 SCR 388, 31 DLR 4th 1.

that can result from it, have persuaded me that it can never safely be determined that such a procedure is for the benefit of that person. Accordingly, the procedure should never be authorised for non-therapeutic purposes under the *parens patriae* jurisdiction.”

The courts have been asked to rule in a number of cases concerning the sterilisation of female patients. However, in *Re A. (medical treatment: male sterilisation)*,¹ the Court of Appeal was asked to rule upon the sterilisation of a mentally incompetent man. A. was a 28 year old man with Down's Syndrome. He was assessed as borderline between significant and severe intelligence impairment. A. was living with his mother and on three days each week he attended a day centre. While incapable of making a decision regarding sterilisation himself, he was sexually aware and active. His mother supported his sterilisation. She was concerned that, as she suffered declining health, she might be unable to supervise him herself and that as a result he might get a woman pregnant. The Court of Appeal held that the sterilisation should not at present go ahead. In a case, as here, which concerned a mentally incompetent patient there was a duty to act in the best interests of that patient. Dame Elisabeth Butler Sloss P. indicated that, at a time when there was soon to be direct application of the European Convention of Human Rights in English law, the court should be slow to take a step which may infringe the rights of those who are unable to act for themselves. They emphasised that the patient's best interest was something which was different from the interests of carers or others. The Court of Appeal, however, left open the extent to which the interests of third parties should be weighed in the balance when determining what was in the patient's best interests. It was noted that such a decision should not be authorised on eugenic grounds. Moreover, a decision to sterilise a female patient involved different considerations and that in the context of a man there were no direct consequences other than the fact that he may contract a sexually transmitted disease. Each case had to be determined on its merits. Here there was, for example, no indication that the level of supervision given to A. would differ if the sterilisation operation was undertaken.

Abortion

The House of Lords in *F. v. West Berkshire Health Authority* declined to specify what special forms of medical treatment other than sterilisation would be suitable for prior judicial declaration. Sir Stephen Brown in *Re SG (a patient)*² observed that the Master of Roles had indicated that an abortion would fall within the “special category” of treatments warranting prior judicial approval, but there was no formal decision taken. Sir Stephen held, however, that an abortion undertaken in

¹ [2000] F.C.R. 193.

² (1990) 6 BMLR 95, *The Times*, 31 January 1991 (Transcript: Nunnery).

accordance with the Abortion Act 1967 is not “special” and could be performed without prior judicial approval. Sir Stephen accepted the Official Solicitor’s submission that since the termination of pregnancy is “so closely regulated by statute, it is not essential as a matter of practice to seek a declaration from the High Court before carrying out such a treatment.”

The conditions of section 1 of the Abortion Act must be complied with in order for an abortion to be conducted without High Court approval. These conditions are: if the woman is less than 24 weeks pregnant and the continuation of the pregnancy would involve a risk, greater than if the pregnancy were terminated, of injury to her physical or mental health or that of any child of her family¹—the so-called “social ground” for abortion. An abortion may also be authorised where it is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman.² In addition, abortion is lawful if continuation of the pregnancy involves a risk to the life of the woman greater than if the pregnancy was terminated.³ Finally, an abortion may be sanctioned where there is a substantial risk that a child would be born seriously mentally or physically handicapped.⁴ The meaning of seriously mentally or physically handicapped is not defined in the Act.

Human Tissue Transplants

Human tissue transplants by mentally incompetent donors present a different kind of case because a significant benefit will flow to another person. By what standard should tissue transplants be judged and is prior judicial review desirable? The court in *Re Y (Mental Incapacity: Bone Marrow Transplant)*⁵ decided a case involving a proposed bone marrow transplant from an incompetent donor with severe mental and physical disabilities to her sister. The transplant offered the only realistic prospect of recovery for the sister.

The court, consistent with the clear consensus of judicial opinion, held that the test to be applied was whether the transplant was in the **best interests** of the mentally incompetent donor.⁶ The potential benefits to the recipient of the transplant were not relevant, except to the extent that the donor received a distinct benefit. In this case, the close family relationship among the two sisters and their mother suggested the donor would receive an emotional, psychological, and social benefit. The benefits should be weighed against any risks or detriments imposed by

¹ Section 1(1)(a).

² Section 1(1)(b).

³ Section 1(1)(c).

⁴ Section 1(1)(d).

⁵ [1996] 2 FLR 787, [1997] Fam Law 91, [1997] 2 WLR 556, [1997] 2 FCR 172.

⁶ The court explicitly rejected the substitute judgment standard sometimes adopted in American courts. Under a substitute judgment standard the court assesses what the patient would have wanted had she been competent.

the transplant. In this case, the court was satisfied that the risks were minimal because the procedure was unintrusive, the bone marrow harvested is speedily regenerated, and there were no long-term consequences to the donor. If the risks had been more serious the court may well have come to a different conclusion. The court held, moreover, that transplantation cases of this kind fell within a category of cases in which it would be “appropriate for the matter first to be ventilated in court before the procedure took place.”

Special Forms of Medical Treatment Suitable for Prior Judicial Declaration

Since *F. v. West Berkshire Health Authority*, courts have been reluctant to identify special forms of medical treatment that would be suitable for prior judicial declaration. Rather, the courts have preferred to view medical diagnosis and treatment as in the patient’s best interests and, therefore, lawful, with no need for prior judicial approval. In *Re GF (medical treatment)*¹ an adult mental patient was suffering from increased distress from excessive menstruation. The court concluded that a hysterectomy was in her best interests. The court declined to make a declaration because the proposed operation was therapeutic, even though it would result in sterilisation.

In *Re H (mental patient)*² an adult mental patient diagnosed with schizophrenia was suspected of having a brain tumour. She was strongly opposed to undergoing a CT brain scan, which requires a general anaesthetic and the injection of a contrast medium. The court held that this was not a special case where it was necessary to grant a declaration. The CT scan was in her best interests and there was no reason to distinguish between diagnostic and therapeutic procedures. The court observed that a declaration “might be an unfortunate signal to others in the future that it was appropriate as a matter of good medical practice . . . pending the outcome of a costly [and time consuming] application to the court.

Practice to be Followed in Seeking Prior Judicial Declaration

In *Re MB*,³ the court outlined the steps which should be followed when the medical profession feels it is necessary to seek judicial declarations prior to administering treatment to incompetent adults. The threshold question is whether the patient’s competency is at issue. If it is not, treatment cannot be administered once the patient has refused to give consent. If there is a question regarding the patient’s competency, a ruling should be sought from the High Court. Both the hospital and the patient should have the opportunity to obtain legal advice. Whenever

¹ [1992] 1 FLR 293.

² 9 BMLR 71, [1993] 1 FLR 28, [1993] Fam Law 131, [1992] FCR 707.

³ *Re MB, The Independent* 8 April 1997, *The Times* 18 April 1997 (Transcript: Smith Bernal), C.A. (Civil Division).

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possible, problems should be identified as early as possible so as to prevent the necessity of the court needing to make a decision in an emergency context without adequate notice and preparation. *Ex parte* hearings should not be held unless clearly necessary. The patient should be represented by counsel, unless the patient does not wish to be represented. A guardian *ad litem* should be appointed if the patient is unconscious. The Official Solicitor should be notified of all applications to the High Court and should be prepared to act as *Amicus Curiae*. Evidence, preferably from a psychiatrist, should be provided as to the patient's competency, and information about the patient's circumstances and background should be available to the judge.

20.16.2 *No court now has jurisdiction either by statute or derived from the Crown as *parens patriae* to give or withhold consent to medical treatment of an incompetent adult*

The House of Lords in *F. v. West Berkshire Health Authority* found that the courts had no jurisdiction either by statute or derived from the Crown as *parens patriae* to approve medical treatment for mentally incompetent adults.

(a) *parens patriae* jurisdiction – The origin of the Crown’s *parens patriae* jurisdiction over mentally incompetent persons is thought to be the *Statute de Prerogativa Regis* (17 Edw. (1339) St. I. cc. 9,10). (See para. 23.01 *post*). The ancient origins of the *parens patriae* jurisdiction was based upon proprietary interests, and it is therefore difficult to determine the extent of the inherent powers to protect the ward, for example by beneficial medical treatment. Nevertheless, the original Statute and early cases and commentary suggest that the *parens patriae* jurisdiction extended to incompetent adults.

Blackstone wrote that the King had the authority to act as “the general guardian of all infants, idiots and lunatics.”¹ The sovereign held a duty to care for all persons who had lost their intellects and become incompetent to care for themselves.² Pursuant to the *parens patriae* powers the sovereign was required to promote the interests and welfare of his wards;³ and could not act contrary to those interests.

The inherent *parens patriae* power of the court to protect incompetent adults appears well settled in other common law countries. The Canadian Supreme Court notes that “In time wardship became substantively and procedurally assimilated to the *parens patriae* jurisdiction, lost its connection with property, and became purely protective in nature. . . . [It follows] that the wardship cases constitute a solid guide to the sense

¹ W. Blackstone, *Commentaries*, vol. 3, p. 47.

² *Beverley’s Case*, 4 Co. Rep. 123b, 127a–28a, 76 Eng. Rep. 1118, 1125–26 (K. B. 1603); W. Blackstone, *Commentaries*, Vol. 1, p. 304.

³ *Rebecca Owings’ Case*, Bland’s Ch. 290, 294 (Md. 1827). *In Re Colah* (The Parsee Merchant’s Case) 3 Daly 529, 537–39, II Abb: Pr. (n.s.) 209, 219–22 (N.Y.C.P. 1871).

of the *parens patriae* power even in the case of adults.”¹ In the United States, the *parens patriae* power has been used to justify state powers over mentally ill adults since *In re Oakes*² where Chief Justice Shaw held that “the great law of humanity” justified state intervention for the person’s ‘own safety.’”

It is reasonably clear, therefore, that the common law provided an inherent *parens patriae* jurisdiction for the courts to protect the medical interests of incompetent adults. The current dilemma is whether this common law jurisdiction was wholly supplanted by statute, or whether there is a residual jurisdiction in the courts.

Halsbury’s Laws of England, vol. 8 (1974) para. 901 states that “the care and commitment of persons and estate of mentally disordered persons, which belong to the Crown at common law from very early times, and was invariably delegated to the Lord Chancellor by warrant under the sign manual, is now entirely covered by statute.”

Mr Justice Wood in *Re. T, T. v. T. and Another*³ held that the court had no residual jurisdiction to order beneficial treatment of an incompetent adult. (As to the facts of the case, see para. 20.09 above).

Lord Brandon observed that “so much of the *parens patriae* for jurisdiction as related to minors now survives in the form of the wardship jurisdiction of the High Court, Family Division. . . . So much of the *parens patriae* jurisdiction as related to persons of unsound mind no longer exists.” It ceased to exist because of section 1 of the Mental Health Act 1959 which revoked previous enactments with respect to the reception, care and treatment of mentally disordered persons; and because of the revocation by Warrant under the Sign Manual of the last Warrant dated 10 April 1956, by which the jurisdiction of the Crown over mentally disordered persons had been assigned to the Lord Chancellor and the judges of the High Court, Chancery Division. “The effect of section 1 of the Act of 1959, together with the Warrant of revocation referred to above, was to sweep away the previous statutory and prerogative jurisdiction in lunacy, leaving the laws relating to persons of unsound mind to be governed solely . . . by the provisions of the [Mental Health] Act. So far as matters not governed by the [Mental Health Act] are concerned, the common law relating to persons of unsound mind continue to apply.”⁴ It follows, said Lord Brandon,

¹ *Re Eve* [1986] 31 DLR 4th I.

² 8 Law Rep. 122 (Mass. 1845).

³ [1988] Fam. 62.

⁴ The Mental Health Act does not cover all aspects of the care of a mental patient. In *R v. Kirklees Metropolitan Council ex parte Cawley*, CO/54/90, *The Times*, 10 February 1992 (Transcript: Marten Walsh Cherer) 6 February 1992, Kennedy J found that section 131 of the 1983 Act, which provides for informal admission to hospital, did not fill the field. Any adult can agree to enter a mental hospital even if he or she does not require treatment for mental disorder as stated in section 131(1). See para. 10.02 ante.

that *parens patriae* jurisdiction is not now available to be invoked to seek approval of the court for medical treatment of mentally incompetent adults.

(b) *Jurisdiction under Part VII of the Mental Health Act 1983* – Part VII of the Mental Health Act provides for the management of the property and affairs of patients by the Court of Protection. (See paras. 23.01 to 23.13 post). Lord Brandon found that the expression, “affairs of patients” does not include medical treatment. When one examines the general tenor of Part VII of the Act, the expression “affairs of patients” should be construed as including only business matters, legal transactions and other similar financial concerns.

(c) *Jurisdiction to make declarations* – Lord Brandon observed that the High Court undoubtedly has jurisdiction to make a declaration with regard to the lawfulness of medical treatment of an incompetent adult. Having regard to the present limitations on the jurisdiction of the court, he said (contrary to the unanimous view of the Court of Appeal) that the procedure by way of declaration is appropriate and satisfactory.

20.16.3 *Standard for Declaring the Lawfulness of Medical Treatment for Incompetent Adults*

Lord Bridge said that it is “axiomatic that treatment which is necessary to preserve the life, health or well being of the patient may lawfully be given without consent.”¹ A consultant in charge of the treatment of an incompetent patient may not only be authorised to administer treatment which is necessary, but he may also be under a common law duty to do so.

If a rigid criterion of necessity were to be applied to determine the lawfulness of treatment of incompetent persons, then they might be deprived of beneficial treatment which is not strictly necessary. It is for that reason that the House of Lords adopted a “best interests” test to determine the lawfulness of treatment for incompetent persons. The House of Lords sought to place vulnerable incompetent patients in the same position as competent patients by ensuring that they receive all medical treatments deemed to be in their best interests. The treatment will be in patients’ best interests, said Lord Brandon, “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.”

Lord Bridge opined that if doctors administer curative or prophylactic treatment which they believe is appropriate for patients, the lawfulness of that treatment should be judged by a single standard. That standard is that doctors will not be liable if they establish that they acted in

¹ For further discussion of the doctrine of necessity see the judgment of Lord Goff in *In re F.* [1990] 2 A.C. 1.

accordance with a practice accepted at the time by a responsible body of medical opinion skilled in the particular form of treatment in question.

The *Bolam* test was adopted by the House of Lords in respect of the treatment of incompetent patients despite the fact that all three members of the Court of Appeal considered that it was insufficiently stringent for deciding whether medical treatment is in a patient's best interests. (As to the *Bolam* test, see para. 20.12.1 above).

Lord Jauncey, while concurring with the use of the *Bolam* test, emphasised that "convenience" to those charged with the care of incompetent persons should never be a justification for treatment.

20.16.4 Commentary

The House of Lords decision in *F. v. Berkshire Health Authority* swept away any doubt that the common law would allow beneficial medical treatment for mentally incompetent patients. The concern that vulnerable incompetent patients should receive the same high standard of medical care as any other patient clearly led the Court to make it as easy as possible to provide treatment to incompetent adults without fear of legal liability. This is a valid and humane concern. But the decision goes so far in that direction that it leaves very little room for safeguards against treatment where the efficacy, safety, or morality is open to dispute.

The most effective safeguard would be a requirement that the High Court approve treatment prior to its administration. The Court of Appeal unanimously expressed the view that the court's review of sterilisation should not merely be a declaration of its lawfulness, but an approval of the operation.¹ The Court of Appeal took this view because a declaration is not strong enough; that it might be unopposed; and that the public interest requires that the court gives express approval to such a socially controversial procedure as sterilisation. While the House of Lords believed that a declaration had virtually the same effect as approval, it did emphasise the profound human rights implications of the procedure. If prior judicial review is, in practice, as important as the House of Lords properly believed, then the law should be altered to require a prior approval of sterilisations. This would put the mentally incompetent adult in the same position as a minor. There is, after all, very little difference between sterilising a mature minor and sterilising a young adult of child bearing age. Mr Justice Wood in *Re T*, and *T. v. T.*² said that the simplest remedy would be to issue a fresh warrant restoring common law jurisdiction.

The House of Lords viewed sterilisation as special, warranting prior judicial review as a matter of good practice. But it declined to speculate

¹ In *Re F* [1990] 2 A.C. 1.

² [1988] Fam. 62.

what other medical procedures might also merit the involvement of a court. The danger of the House of Lords judgment is that it might open the door to unilateral decisions to treat incompetent patients with controversial or invasive procedures without the independent safeguard of a review by a court. It is suggested that any medical treatment which is ethically controversial, where persons other than the patient stand to gain, or where the medical efficacy or safety of the procedure is in doubt, that prior judicial review should be sought. Prior judicial review would also be desirable where the patient, although technically incompetent, has expressed reluctance to consent to the treatment, or where there is some disagreement among the patient's family or among the therapeutic team concerning the need for the treatment.

Throughout the House of Lords opinions several standards of review were variously enunciated: necessity, best interests, and negligence (the *Bolam* test).¹ These are three quite different standards, which would have very different results when applied to individual cases. Some medical procedures, for example, may be quite beneficial to patients, but they may not be strictly necessary. The adoption of a standard of best interests rather than necessity is humane and dignified. It helps to ensure that patients who are unable to request treatment to promote their own health and well being are not deprived of beneficial medical care.

The adoption of the *Bolam* standard, however, may actually be detrimental to the patient's best interests. The *Bolam* test is, by far, the most lenient and permissive of the three tests. It, therefore, becomes the lowest common denominator against which all treatment for incompetent patients will be measured. Treatment may well be administered without negligence. But if it represents only a minority medical view, and there are other courses of action that would be preferable for the patient, it is not in the patient's best interests. The adoption of the *Bolam* standard, contrary to the House of Lords assertion, does not put the incompetent patient in the same position as the competent patient. The competent patient need not follow the advice of his doctor, and can refuse treatment he deems not to promote his interests. He also need not rely on one doctor, but can seek a second opinion or other advice. The incompetent patient in a mental hospital under the care of a consultant should be entitled to insist not merely on non-negligent treatment, but treatment which in all the circumstances is in his or her best interests.

Perhaps more important is the question of who is to decide the treatment that the incompetent patient is to receive. The unspoken assumption in the House of Lords opinions is that the decision is to be taken by the patient's doctor. But there are many potential decision-

¹ Lord Brandon's definition of best interests comes close to the test of necessity, and could confuse the two: treatment is in a person's best interests only if it is carried out to save life, or to ensure improvement or prevent deterioration in physical or mental health.

makers who could purport to act in the patient's best interests, including his family and a variety of health and social services professionals in the multi-disciplinary team.

What safeguards are there for the incompetent patient when a treatment is medically or ethically controversial? Some system of safeguards ought to be considered. This could, for example, include a required second medical opinion, a review by the Mental Health Act Commission (whose jurisdiction would have to be extended to informal patients), or a review by an institutional review committee or hospital ethics committee. A duty to consult relatives could also be adopted.

Finally, the House of Lords' decision does not sufficiently take into account complex or difficult cases. Most of the Court's opinions appeared to have in mind the permanently incompetent person. But often patients have varying degrees of competence which may change over time. The views of patients ought, wherever possible, be taken into account. Some patients have expressed views about treatment before becoming incompetent; others may enunciate current opinions which, while not wholly lucid, may express their feelings; and others may attain greater understanding and competence in the future. Where a patient's past, present or future views are ascertainable they represent powerfully important evidence to consider in deciding about treatment. Certainly, a distinction ought to be made between the non-volitional patient and the protesting patient. Very good reasons should exist before deciding to impose treatment on a protesting, albeit incompetent, patient. It is also necessary to take into account the kind of treatment proposed. Is it for purely medical reasons such as the removal of a cataract? Are there social implications such as sterilisation or abortion? Does the convenience of the staff have any role to play such as seclusion, restraint or excessive use of sedatives? Are there less restrictive or less intrusive alternatives? These are complicated personal, social, and moral judgments which go well beyond the expertise of a single doctor being held accountable only under the permissive *Bolam* standard.

20.16.5 *Practice Pointers*

The Code of Practice makes clear that decisions concerning competency and consent are matters of clinical judgement, and are the doctor's responsibility. The doctor's judgement regarding competency and consent should be recorded in the clinical notes. The basic principles for determining competency include comprehension of the broad terms of the treatment, benefits, risks, and the consequences of not receiving it. A person's competency is highly individual and is variable over time and in relation to the particular treatment.

The Code recommends that treatment in the person's best interests should be provided in cases where he is incapable of giving consent.

Specific examples include: (a) an immature child, in which case the parent or guardian may consent; (b) a person who is unconscious and there is an urgent need to preserve life, health, or well-being (unless there is clear evidence of a prior directive not to be treated in that situation); (c) a person suffering from mental disorder resulting in behaviour that is an immediate and serious danger to himself or others and it is not possible immediately to use Part IV of the Act. (Treatment should be the minimum necessary to avert that danger.)

“Best interests” is defined as treatment necessary to save life or prevent a deterioration or ensure an improvement in the patient’s physical or mental health. Treatment must also be in accordance with the standard of care in the medical specialty. (Code of Practice, paras 15.1–15.24).

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C. CONSENT TO TREATMENT UNDER PART IV OF THE MENTAL HEALTH ACT

20.17 Background

There is no issue at the interface of law and psychiatry which is so fundamental as consent to treatment. The Mental Health Act 1959 did not provide guidance as to whether a person compulsorily admitted to hospital could be compelled to receive treatment. Nevertheless there was a commonly held medico-legal assumption that involuntary admission was intimately connected with a patient's subsequent treatment and that the powers pertaining to compulsory admission must necessarily subsume forcible treatment. Official advice was that if a patient was involuntarily admitted for treatment the responsible medical officer would be empowered to administer that treatment in the absence of consent.¹ The implicit assumption was that a patient's competency to consent to medical treatment was conclusively determined by his compulsory admission status. This traditional assumption was being increasingly questioned on the grounds that the 1959 Act did not expressly govern the therapeutic relationship between doctor and patient; Part IV of the 1959 Act was concerned exclusively with admission to hospital and was silent in respect of any express regulation of treatment or consent. In the absence of any such specific statutory provision, the common law right to refuse treatment did not appear to be automatically abrogated in the psychiatric context.²

Involuntary admission to hospital does not, either in law or practice, suggest that a person is wholly incompetent. Psychiatric illness—even if accompanied by a formal legal determination that involuntary admission is warranted—does not render a person entirely unable to make choices about the treatment he is to receive; compulsorily detained patients possess varying degrees of competency to make rational decisions about their own health and body. A detained patient may be able to understand the nature, purpose and effect of one treatment, but not another, and his capacity to understand may vary from time to time.³ This is the working assumption implicit in Part IV of the Mental Health Act 1983.

The 1983 Act is probably the only statute in the history of the law

¹ DHSS et. al. (1978) *Review of the Mental Health Act 1959*, Cmnd. 7320, para. 6.14; Medical Defence Union (1972) *Consent to Treatment*; K. Joseph (Jan. 23, 1973) *H.C. Debs.*, vol. 849, col. 77.

² J. Jacob (1976) *The Right of a Mental Patient to his Psychosis*, *Mod. L. Rev.*, vol. 39, p. 17; L. Gostin (1979) *The Merger of Incompetency and Certification: The Illustration of Unauthorised Medical Contact in the Psychiatric Context*, *Int'l. J.L. & Psychiat.*, vol. 2, pp. 127-168; Confederation of Health Service Employees (1979) *The Management of Violent Patients*, para. 72.3.

³ See the evidence assembled in S. Morse (1978) *Crazy Behaviour, Morals, and Science: An Analysis of Mental Health Law*, *S. Cal. L. Rev.*, vol. 51, pp. 527-654.

of England and Wales which makes comprehensive arrangements for the treatment of patients without consent. It envisages that, once the patient is detained in hospital under certain provisions which allow detention for 28 days or more, he may be liable to have his ordinary common law rights overridden. It will not, however, automatically be presumed that the patient is incompetent or that treatment should be given without consent. Generally speaking, before treating the patient without consent two basic issues must be considered: whether the person is competent to give consent and has in fact consented; and whether, having regard to the potential benefit of the treatment, it should be given. The assumption behind the 1983 Act, then, is that a patient to whom Part IV applies can be treated without his consent only after the foregoing issues have been determined. One of the most controversial issues in the consultative process leading up to the Act was whether the above criteria should be applied by the responsible medical officer himself, an independent doctor or by a lay body.¹ It was suggested that the first criterion (which relates to competency and consent) was essentially a matter for legal and lay opinion; while the second criterion (which relates to the appropriateness of the treatment) was essentially a matter for medical opinion. This was the approach ultimately adopted in respect of treatments which give rise to special concern such as psychosurgery. However, for other kinds of treatment, the decision is effectively placed with the responsible medical officer in the first instance who can certify a patient's consent; if the RMO is not able to certify that the patient has consented, then the decision on whether to give treatment rests with an independent doctor who is either a member of, or appointed by, the Mental Health Act Commission. (As to the background, see further para. 1.11.2 *ante*).

The Code of Practice (para. 16.4) affirms the importance of the doctor/patient dialogue inherent in the process of obtaining truly informed consent. For all patients (whether or not they are informal, detained, or subject to Part IV), and for all treatments, it is necessary first to seek the patient's consent. The responsible medical officer or doctor in charge of treatment has a professional obligation to interview the patient to seek his consent, and to properly record the discussion.

20.18 Patients to whom Part IV Applies

The ordinary common law is applicable in respect of any patient or any treatment which falls outside the scope of Part IV of the Mental

¹ For the debate leading up to the 1982 Act see L. Gostin (1981) Observations on Consent to Treatment and Review of Clinical Judgment in Psychiatry: A Discussion Paper, *J. Roy'l. Soc. Med.*, vol. 74, pp. 742-52 (and see editorial reply by A. Clare (1981) *J. Roy'l. Soc. Med.*, vol. 74, pp. 787-89). See letters: Szmykier (March 6, 1982) *B.M.J.*, p. 568; Gostin (April 3, 1982) *B.M.J.*, p. 801; M. Beedie & R. Bluglass (1982) Consent to Psychiatric Treatment, *B.M.J.*, vol. 284, pp. 1613-1616 (and see reply by Gostin & Russell Davis (June 26, 1982) *B.M.J.*).

Health Act. Part IV applies to any patient **liable to be detained** under the Act except the following (s. 56(1)): those liable to be detained under an application for assessment in cases of emergency (s. 4); a doctor's or nurse's holding power (s. 5(2), (4)); a warrant to search for and remove patients (s. 135); the power of a constable to remove a person found in a public place (s. 136); a direction that an offender be detained in a place of safety pending his admission in pursuance of a hospital order (s. 37(4)); and a remand to hospital for a report on the mental condition of an accused person (s. 35). In addition, Part IV does not apply to a restricted patient who has been conditionally discharged (s. 42(2), 73 or 74) and who has not been recalled to hospital.

Since Part IV of the Act applies only to patients who are "liable to be detained", it does not apply to informal patients or patients subject to guardianship. Patients who are on a leave of absence from hospital under section 17 continue to be liable to be detained and are, therefore, subject to the provisions in Part IV of the Act.

Section 57 of the Act (relating to treatments which give rise to special concern) applies to informal as well as detained patients. See further para. 20.20 below.

20.19 What Forms of Treatment are Governed by Part IV?

If a **patient** falls within Part IV of the Act, the next question which arises is whether the **treatment** is one which is regulated by Part IV. Part IV only replaces the common law in respect of "medical treatment given to him [a patient to whom Part IV applies] for the mental disorder from which he is suffering . . . if the treatment is given by or under the direction of the responsible medical officer" (s. 63).¹

20.19.1 *Treatment must be for mental disorder*

Part IV of the Act is applicable only to "treatment given to him for the mental disorder from which he is suffering". Part IV, therefore, does not apply to treatments given to a patient for physical illness (*e.g.* an appendectomy),² for social purposes (*e.g.* a non-therapeutic sterilisation or abortion) or solely for restraint. Such treatments cannot be given to any patient without his consent unless a justification can be found under the common law such as necessity.

The Queen's Bench Divisional Court in *R. v. Mental Health Commission, ex parte W*³ said that where a mental disorder was quite distinct

¹ The responsible medical officer in Part IV of the Act is the doctor in charge of the patient's treatment (s. 64(1)) See para. 6.17.1 *ante*.

² See *Re C* (adult: refusal of medical treatment) [1994] 1 All E.R. 819; [1994] 1 W.L.R. 290—holding that a schizophrenic patient is entitled to refuse treatment for gangrene, which was entirely unconnected to his mental disorder.

³ *The Times*, May 27, 1988, D.C. Full unpublished decision by Marten Walsh Cherer Ltd.

from sexual deviancy and the proposed treatment was solely for the purpose of dealing with sexual deviancy, it was not treatment for mental disorder. The court came to this conclusion because section 1(3) states that nothing in the Act could be 'construed as implying that a person may be dealt with under this Act as suffering from mental disorder . . . by reason only of . . . sexual deviancy.' (See further para. 9.01 *ante*). The court, however, acknowledged that in practice it seemed likely that the sexual problem would, as here, be inextricably linked with the mental disorder, and the treatment for one would be the treatment for the other.

The Court of Appeal in *B. v. Croydon Health Authority*¹ explored the parameters of "treatment" given for mental disorder in a patient suffering from borderline personality disorder and post-traumatic stress disorder. The patient's illness manifested in her refusal to eat as a means to inflict harm upon herself. The Court held that nasogastric feeding was part of her treatment for mental disorder and was within the ambit of power conferred by section 63; the nasogastric feeding, therefore, could be administered without her consent.

The Court of Appeal referred to the broad definition of "medical treatment" in section 145(1) which includes "nursing . . . care, habilitation and rehabilitation under medical supervision." Consequently, the Court reasoned, "a range of acts ancillary to the core treatment fall within the definition." Relieving symptoms is as much a part of treatment as relieving the underlying cause.²

As noted above, the patient in *B. v. Croydon Health Authority* suffered from psychopathic disorder so, by virtue of section 3(2)(b), she could not be detained unless the treatment was "likely to alleviate or prevent a deterioration of his condition." The Court of Appeal found that medical treatment included a range of acts ancillary to the core treatment, not all of which had to be, in themselves, likely to alleviate or prevent a deterioration of the psychopathic disorder. The ancillary nature of the treatment which could be administered to a patient was further underlined by section 62, which authorizes emergency treatment not directly related to the alleviation of the patient's mental disorder when immediately necessary to save a patient's life or to prevent her behaving violently or endangering herself or others. The Court of Appeal reasoned that although such treatment was more likely to be necessitated by the symptoms of the disorder rather than by the disorder itself, it was assumed by section 62 to be a form of medical treatment for the mental disorder. It follows that medical procedures to alleviate the symptoms, as well as the root causes, constitute treatment for mental disorder within the meaning of section 63.

¹ [1995] 1 All E.R. 683, [1995] 2 W.L.R. 294, [1995] 1 F.L.R. 470, [1995] 1 F.C.R. 6562.

² Re KB (adult) (mental patient: medical treatment) (1994) 19 B.M.L.R. 144 at 146.

The court reached a similar conclusion in *Re KB (adult) (mental patient: medical treatment)*.¹ KB suffered from anorexia nervosa and was detained under section 3. Ewbank J held that feeding by nasogastric tube is treatment for mental disorder envisaged by section 63 and does not require consent. Relieving the symptoms of an eating disorder, the court ruled, is just as much a part of treatment as relieving the underlying cause.²

The court extended this reasoning to allow for the use of restraint to carry out medical treatment in *Tameside and Glossop Acute Services Trust v. CH (a patient)*.³ CH suffered from schizophrenia and was detained under section 3. She was pregnant and refused regular prenatal care. Doctors feared that if labour was not induced or a Caesarean section performed, CH would deliver a stillborn baby. The court found that achievement of a “successful outcome of her pregnancy” was a necessary part of the overall treatment of her mental disorder. The court declared that the doctor was authorized to use restraint to the extent it was necessary to bring about delivery of a healthy baby.⁴

20.19.2 Treatment must be under the direction of the RMO

Part IV applies only to treatment for mental disorder given by or under the direction of the responsible medical officer (RMO); behaviour modification, for example, could not be given by a psychologist without the knowledge of the RMO if Part IV were to be relied upon.

20.19.3 It must be “medical treatment” and not “restraint”

For Part IV to apply the procedure administered must be **medical treatment** for mental disorder. The distinction, therefore, between “treatment” and “restraint” (or other measures) is important. “Medical treatment” is defined widely in section 145(1). (See para. 20.02 above). It is likely that any reasonable measure given by, or under the direction of, the responsible medical officer designed to benefit the patient and to ameliorate or prevent a deterioration in his mental disorder would be regarded as treatment. However, if the primary intention were to restrain or punish it should not necessarily

¹ (1994) 19 B.M.L.R. 144. See *Riverside Mental Health NHS Trust v. Fox*, [1994] 1 F.L.R. 614, 2 F.C.R. 577, 20 B.M.L.R. 1, Ct. of Appeal, 25 October 1993 where the Family Court declared that force-feeding of a patient with anorexia nervosa was treatment under section 63. The order was overturned on appeal because the judge did not have the jurisdiction to make the proposed order.

² The courts in *B. v. Croydon Health Authority* and *Re KB* both concluded that nasogastric feeding was not the administration of medicine and was not subject to the provisions for a second medical opinion contained in section 58. See further, section 20.21 below.

³ [1996] 1 FLR 762 (Family Division).

⁴ In *Norfolk and Norwich Healthcare (NHS) Trust v. W*, 34 BMLR 16, [1997] 2 FLR 613, [1997] Fam Law 17, [1997] 1 FCR 269 (Family Division), a case factually similar to *CH*, the court ruled that although the patient did not suffer from a mental disorder, which would allow treatment under section 63 of the Mental Health Act, she lacked the mental competence to make a decision about treatment, and that treatment was therefore authorized by common law. The court emphasized that the standard to be used was the best interests of the patient. See also sections 20.16 et seq., ante.

be regarded as treatment. The dividing line is not always clear. When, for example, does seclusion change from a valid ("time out"¹) form of treatment to a form of restraint or punishment? It is likely that sedation would be regarded as treatment. But where, for example, the nurse administered PRN² medication with the express intention of restraining the patient, it would not be entirely clear whether that was treatment or restraint. Should not the doctor or nurse who uses medical procedures for the purpose of restraint have to rely on common law powers as opposed to Part IV?

20.20 Treatment Requiring Consent AND a Second Opinion (Section 57)

20.20.1 *To whom does section 57 apply?*

Section 57 applies not only to patients to whom Part IV applies (see para. 20.18 above) but also to any patient who is not liable to be detained under the Act. It clearly applies to any informal patient whether in a mental illness or mental handicap hospital, or a district general hospital. Since it refers to "any patient" arguably section 57 would not apply, for example, to a person serving a sentence of imprisonment. However, the broad terms with which section 56(2) is framed, together with the wide definition of "patient" in section 145(1) ("a **person** suffering or appearing to be suffering from mental disorder"), suggests that section 57 could conceivably apply to any mentally disordered person whether or not the person is in hospital including prisoners. It surely would apply to a person on a psychiatric probation order (see para. 15.25 *ante*) because the person is deemed to be an informal patient in hospital.

Due to a Parliamentary oversight, section 57 technically does not apply to patients detained under the provisions set out in section 56(1)(a)–(c) who are not within the scope of Part IV (*e.g.* patients admitted under section 4) (see para. 20.18 above). It is highly unlikely that serious treatment contemplated in section 57 would ever be given to such patients, and a medical practitioner would be well advised to comply with the safeguards in section 57 as a matter of reasonable professional practice.

20.20.2 *Treatments which give rise to special concern*

Section 57 applies to the most serious forms of medical treatment for mental disorder: (i) psychosurgery—*i.e.* any surgical operation for destroying brain tissue or for detroying the functioning of brain tissue (see para. 20.07 above); and (ii) any other form of treatment specified in the regulations. The only treatment currently specified in the regulations is surgical implantation of hormones for the purpose of

¹ "Time Out" is a form of behaviour modification (see para 20.08 above) where a patient who is acting out or is violent is placed in a room by himself for a very short period until his aggressive behaviour has ceased.

² P.R.N. medication is any prescription a doctor enters in a patient's records for possible use as and when the circumstances dictate.

reducing male sexual drive (reg. 16).¹ The regulations do not control the use of sex hormones administered orally rather than by surgical implantation. The code of practice prepared by the Mental Health Act Commission can also specify treatments which in the opinion of the Secretary of State give rise to special concern and which accordingly should not be given without the patient's consent and a second opinion. (See para. 20.20.5 below).

The Queen's Bench Divisional Court in *R. v. Mental Health Commission, ex parte W*² construed the phrases "surgical implantation" and "hormones for the purpose of reducing male sexual drive." The applicant was a "compulsive and previously convicted paedophile." He received an antiandrogen drug at Ealing Hospital but it was unsuccessful in suppressing his sexual urges. He consented to receive the drug Goserelin, which is manufactured for the treatment of cancer of the prostate. Goserelin operates by reducing the testosterone to castrate levels. The drug had not been proven safe and effective for that use, and was, therefore, experimental. The treatment consisted of a monthly subcutaneous injection of an implant into the abdomen, which degrades over the ensuing month gradually releasing the drug. A total of three injections were given and the applicant was satisfied.

The Mental Health Act Commission concluded that the treatment came within the ambit of section 57 and declined to issue a certificate to authorize the treatment.

The court held that the Commission had no jurisdiction to refuse to certify the treatment because it was not a hormone and it was not surgically implanted. The court's reasons for this conclusion, however, delved into pedantic scientific distinctions which in all likelihood were not even considered by Parliament.

The court said that the use of the word "hormone" in Regulation 16(1)(a) must have been intended to include synthetic equivalents to the normally occurring substance. That much is clear, for it is unlikely that the regulation intended to confine the term to the exogenous use of a natural substance: and it is well known that the Regulation was in fact directed to a drug called Oestradiol, which is a synthetic equivalent of the female hormone Oestrogen. But the court said that Goserelin was not a synthetic equivalent of a naturally occurring hormone, but was a synthetic analogue of a luteinising hormone releasing hormone (LHRH), or a chemical compound having a similar or apposite action metabolically.

In devising the Regulation the intention was to provide protection to mentally disordered people against treatment with the effect of reducing male sexual drive. Goserelin has that effect and is, in fact, significantly

¹ See Robert's case described in *A Human Condition* (1977: vol. 2), pp. 89-91.

² *The Times*, May 27, 1988, Stuart-Smith, LJ and Farquharson, LJ. Reported *sub nom. R. v. Mental Health Act Commission, ex parte X* (1988) 9 BMLR 77. For further discussion of the case see P. Fennell *Sexual Suppressants and the Mental Health Act 1983* [1988] Crim. L.R. 660-676.

more potent. There is little evidence that a close regulatory distinction would be made among three highly interrelated treatments for sexual deviance: naturally occurring hormones, synthetic equivalents and synthetic analogues.

The court also determined that a monthly subcutaneous injection of an implant was not a "surgical implantation". The phrase "surgical implantation" was a matter of impression, and the court's impression was that an "injection by conventional hypodermic syringe, as Goserelin was administered, could not be described as surgical means." The term surgical, if widely construed, could apply to any cut in the skin with a medical instrument; the term "surgical" is often used in distinction to the use of drugs in medicine.

The court gave no reason for preferring the narrow, rather than the wide, construction of the term. One reason for the wider construction would be that section 57 is designed to protect mentally disordered people from treatments which give rise to special concern; it is unlikely that the precise method of implantation would have been so important in devising the regulation. Moreover, as the applicant argued, it is only the advance of modern technology that improved the technique of implantation, and it would be wrong if the regulations could be so evaded.

The court decided that, even if the treatment Goserelin were regarded as a surgical implant of hormones within the ambit of section 57, the Commission, nonetheless, should have issued a certificate authorising it. This is because the patient gave an effective "consent" and it was an "appropriate" treatment. There follows a description of the legal and practical requirements for issuing a certificate for a treatment under section 57.

20.20.3 Procedure for giving treatment under section 57

Subject to section 62 (which relates to emergencies; see para. 20.27 below) the foregoing treatments cannot be given unless **both** of the following requirements are met:

(i) **Consent**—There must be a certification¹ in writing that the patient is capable of understanding the nature, purpose and likely effects of the treatment. (This is the statute's definition of competency). The phrase "nature, purpose and likely effects" is not explained in the Act, and clearly competency will vary widely among patients. If the patient must be capable of understanding these things, it should follow that he must be given the necessary information to enable him to understand. Thus, it must be explained to the patient, in terms that he can compre-

¹ The certificates required for the purposes of section 57(2)(a) and (b) must be in the form set out in Form 37 of the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, S.I. 1983, No. 893 (s. 64(2), reg. 16(2)). The certificate for a treatment may have a time limit imposed by the person(s) signing the certificate.

hend, how and why the treatment is to be administered, and the benefits, material risks and side effects of the treatment. All foreseeable adverse effects should be explained to the patient. The Act only refers to “likely effects”. However, it would be prudent to explain (but not necessarily emphasise) risks which were only possible (not likely) if the risk carries potentially serious consequences—for example, the small risk of epilepsy when psychosurgery is performed.

Consent must be real in the sense that it is voluntary—*i.e.*, consent must be given without misrepresentation or improper threats or inducements. (See common law requirement discussed at para. 20.14 above and para. 21.05.2 *post*).¹

The certificate must be signed by three independent people: a registered doctor (not being the responsible medical officer), and two other persons (not being registered medical practitioners), all of whom are either members of, or appointed by, the Mental Health Act Commission (s. 121(2)(a), (3)). Before signing a certificate they should be satisfied that full information was given to the patient in a form which he was capable of understanding and in fact that he consented.

The only case thus far to examine the “consent” provisions of section 57 is *R. v. Mental Health Act Commission ex parte W²* (As to the facts and other part of the holding in the case see para. 20.20.2 above). The Commissioners refused to issue a certificate authorising the drug Goserelin which was being used as a treatment for sexual deviancy. The Commissioners decided that the patient was incapable of giving consent and, therefore, the experimental treatment should not be given.

Stuart-Smith, LJ held that the bald assertions by the Commissioners that the patient’s mental condition had so gravely deteriorated between the commissioners’ visits as to have resulted in a change in his capacity to understand was not persuasive. The Commissioners do not have the authority to apply any test which they deem fit. The test to be applied was enunciated in *Chatterton v. Gerson*³: “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. . . .” (See further paras 20.11–20.13 above).

The Commissioners had to decide if the patient was capable of understanding the nature and likely effects of the treatment. There can be no doubt that the applicant knew this, including the fact that the full

¹ The interaction between statute and common law is not specified in the Mental Health Act. Except for the standard of competency and, possibly by implication, the amount of information that should be disclosed, it is suggested that the common law should be referred to for determining whether consent is legally effective. See paras 20.10–20.15 above. A careful legal study of this question is called for.

² *The Times*, May 27, 1988. Reported *sub nom. R. v. Mental Health Act Commission, ex parte X* (1988) 9 BMLR 77.

³ [1981] 1 Q.8. 432 at 442.

effects of the treatment on young men had not been studied. It was not necessary for the patient to understand the full physiological effects of the treatment.

The court's decision that a patient must only be capable of understanding the nature and likely effects of the treatment is probably an accurate statement of the law. However, the court went on to draw an apparent distinction between capacity to understand and true understanding: "The words used [in the Act] were 'capable of understanding', so that the question was capacity and not actual understanding. The issue was the patient's capacity to understand the likely effects of the treatment and not possible side effects however remote."

There is a fine line, if any, between "capacity to understand" and true understanding. If a person is capable of understanding, and if he is given full information in the correct manner, there is no reason he should not understand that information. The preferred legal view is that a patient must understand the nature and effects of the treatment, including foreseeable adverse effects. It is probably not necessary for him to understand the scientific rationale for the treatment nor very remote risks.

And

(ii) **Appropriateness of the treatment**—The independent doctor referred to above must certify in writing¹ that, having regard to the likelihood of the treatment alleviating or preventing a deterioration of the patient's condition, the treatment should be given. In making such a decision it would seem prudent to be fully informed both as to the nature of the psychosurgery (e.g. stereotactic or freehand—see para. 20.07 above) and the record of the hospital in performing that operation over a number of years. Before giving a certificate the doctor must consult two other persons who have been concerned with the patient's medical treatment—one of whom must be a nurse and the other neither a nurse nor a doctor. These other persons could be a psychologist, social worker or occupational therapist who has had a direct involvement in the treatment of the patient concerned. Consultation should involve a process of full exchange of information and the genuine seeking of advice.

The court in *R. v. Mental Health Act Commission, ex parte W²* also held that the Commissioners had to consider whether the proposed treatment would alleviate the condition or prevent its deterioration. Their decision to refuse the certificate under s. 57(2) would have to be quashed on the grounds that they took into account matters which they should not have taken into account, applied the wrong test and reached a decision that was *Wednesbury* unreasonable.

¹ See section 64(2) and reg. 16(2) discussed at note 2 above.

² *The Times*, May 27, 1988. Reported *sub nom. R. v. Mental Health Act Commission, ex parte X* (1988) 9 BMLR 77.

“The Commissioner must first consider whether the proposed treatment is likely to alleviate the condition or prevent its deterioration; if he concludes that it is not so likely, then he must refuse a certificate; if he concludes that it is likely to do so, then no doubt he may balance the benefit against what he conceives to be the disadvantages.” Stuart-Smith LJ decided that, on the evidence available to the Commissioner, he should have concluded that the drug Goserelin was alleviating the patient’s condition. “If nevertheless it [the certificate authorising treatment] was not to be permitted on the grounds that other considerations outweighed these advantages . . . the majority of those considerations are criticisms of Dr Silverman [the RMO], at the very least they should have been discussed with him and that a failure to do so amounts to unfairness to the Applicant or the taking into consideration of irrelevant matters.” See further “duty to act fairly” below.

20.20.3A *Commissioners’ Duty to Act Fairly*

The court in *R. v. Mental Health Act Commission ex parte W¹* held that the commissioners were under a duty to act fairly (see further para. 20.20.3 above). The commissioners erroneously reached their conclusions on both limbs of the criteria for issuing a certificate under section 57:-viz, consent and appropriateness of treatment. Stuart-Smith LJ did not clearly enunciate what is entailed in the duty to act fairly. But the Lord Justice did indicate that “it would have been preferable if the commissioners had told the patient they were reconsidering their previous decision and that they needed to be satisfied that he still had the capacity and had given consent.”

Stuart-Smith LJ emphasised that “I am far from saying that in every case the medical Commissioner must discuss every reservation that he may have with the Responsible Medical Officer.” But most of the issues of the case involved criticism of the RMO’s approach and treatment which ought to have been discussed. Failure to do so amounted to unfairness.

The commissioners, then, probably have a duty to act fairly which entails some discussion with the patient on matters of consent and the RMO on matters of the appropriateness of the treatment, particularly where such discussion could shed additional light on their decision-making. (As to the Commission’s duty to disclose documents to patients or their advisors, see para. 22.14B *post*).

20.20.4 *Commentary*

The requirements listed above are intended to provide two independent safeguards: the first represents a legal and lay judgment,

¹ *The Times*, May 27, 1988. Reported *sub nom. R. v. Mental Health Act Commission, ex parte X* (1988) 9 BMLR 77.

taken on a multi-disciplinary basis, that the person is competent and has consented. If the patient is incompetent to give consent or if he withholds consent, that is the end of the matter. The treatment cannot be given, irrespective of how much the patient may benefit (unless there is an emergency within the meaning of section 62; see para. 20.27 below). Since psychosurgery is usually indicated only in cases of severe affective disorders, the competence of the patient may often be in doubt. Arguably, psychosurgery may not be given in those cases where it is most needed.

The second test is medical in nature and is decided upon only by an independent doctor. Thus (even if the patient is competent and freely consents) the treatment cannot be given if the independent doctor finds that it is not medically appropriate. Section 57 is the only statutory provision in England and Wales which stipulates that, even if a competent patient consents to a medically recognised treatment, it cannot be given unless there is independent verification that he is competent to give consent and that the treatment will be beneficial. The State therefore has intervened in cases where the doctor and patient freely enter a relationship and agree on the need for a medically recognised treatment. The justification for interfering with a voluntary therapeutic relationship is that these particular treatments give rise to special concern since they may be irreversible, unusually hazardous or not fully established.¹

20.20.5 *Code of Practice*

The Secretary of State for Health (on the advice of the Mental Health Act Commission) has prepared, and from time to time will revise, a Code of Practice (s. 118). The first revision was published by the Department of Health and Welsh Office in 1993.² (As to the Code of Practice see para. 22.14 *post*). The Code of Practice gives guidance to doctors and other professionals in relation to the medical treatment of patients.

The Code (paras 16.6–16.7) recommends that, because of the public and professional concern about section 57 treatments, procedures for implementing those treatments must be agreed between the Commission and the hospitals concerned. Before the responsible medical officer or doctor in charge of treatment refers the case to the Commission, he should be satisfied that the patient is competent and has consented; and the patient and (if the patient agrees) his family should be informed that the final decision still must be taken by the Commission.

¹ See Gostin (1982) *Psychosurgery: A Hazardous and Unestablished Treatment? J. Soc. Wel. L.*, pp. 83–95.

² Department of Health and Welsh Office *Code of Practice: Mental Health Act 1983* (1993) London, HMSO.

A clinical decision must be taken that psychosurgery or surgical implant of hormones will be an effective treatment for mental disorder, and will not produce undue adverse effects. A patient should not be transferred to the neuro-surgical centre for psychosurgery until the case is first referred to the Commission. The Commission will usually visit and interview the patient.

The Code of Practice (para. 16.8) emphasises that section 57 only applies to the surgical implantation of hormones when it is administered as a medical treatment for mental disorder. This implies that implantation for purely behavioural reduction in sexual drive (not related to mental disorder) could be given without meeting the requirements of section 57. For example, a prisoner who receives an implantation simply for the purpose of early release would receive no safeguard under the Act. This is not as clear or simple a proposition as the Code may suggest. The line between a purely behavioural sexual deviancy and mental disorder is highly uncertain. No reliable data exist to differentiate between sexual deviances based upon psychiatric etiology or presentation of symptoms. Further, section 57 is designed to protect a broad range of individuals, not only patients in psychiatric hospitals. The proposition that surgical implants may be administered to prisoners without any safeguard needs careful thought.

The Code of Practice may specify forms of medical treatment in addition to those mentioned in the regulations made for the purposes of section 57 which in the opinion of the Secretary of State gives rise to special concern (s. 118(2)). However, the current Code does not specify any additional treatments for the purposes of section 57.

Were treatments to be designated in any future revision of the Code they would have similar (but not identical) safeguards. Such treatments could not be given unless the patient consented and a written certificate was given to the matters specified in section 57(2) (a) and (b) (see para. 20.20.3 above). The certificate would not be given by three people as required under section 57, but only by a medical practitioner who is a member of, or appointed by, the Mental Health Act Commission (s. 121(2)(a), (3)). The doctor must certify that the patient is capable of understanding the nature, purpose and likely effects of the treatment and that he has consented to it; and that, having regard to the likelihood of the treatment alleviating or preventing a deterioration of the patient's condition, the treatment should be given (s. 118(2)). The code of practice does not have the same force of law as the statute or regulations; however, the courts can be expected to pay very close regard to the code in examining the doctor's duty of care.

20.21 Treatment Requiring Consent OR a Second Opinion (Section 58)

20.21.1 *Treatments to which section 58 applies*

Section 58 applies to: (a) forms of treatment which are specified in the regulations. Currently the only treatment specified is electroconvulsive therapy (reg. 16(2)); and (b) the administration of medicine by any means (*i.e.* orally or by injection) “at any time during a period for which he is liable to be detained as a patient to whom this Part of the Act applies if three months or more have elapsed since the first occasion in that period when medicine was administered to him. . .”. This is the “three months rule”,¹ which is discussed at para. 20.21.2 below.

20.21.1A *Electroconvulsive therapy*

The responsible medical officer has a professional obligation to first seek valid consent. Form 38 should be completed where the patient consents. The completed form should include the proposed maximum number of applications of ECT, which should also be included in the patient’s treatment plan. The procedures specified at para. 20.21.3 below must be followed where the patient cannot or will not give valid consent and the doctor wishes to proceed with the treatment. (Code of Practice, para. 16.9).

20.21.1B *Medication after three months*

The responsible medical officer should seek the patient’s consent before administering any medication.² If medication is administered (with or without valid consent) the RMO should personally interview the patient again at the expiration of three months to seek consent for the continuation of the medication. Form 38 should be duly completed if the patient consents. The RMO should certify the drug proposed and the method of administration. The drug should be classified according to the British National Formulary and dosage indicated if it is above the BNF maximum limits. The procedures for giving treatment under section 58 described in para. 20.21.3 below should be followed if the patient cannot or will not consent. (Code of Practice, para. 16.11).

20.21.2 *The “three months” rule*

The “three months rule” means that medication can be administered for three months without the consent of the patient or a second opinion. The three months period commences when the medication is

¹ By section 58(2) the Secretary of State for Social Services may by order vary the length of the period.

² Courts have concluded that nasogastric feeding is not the administration of medicine and is not subject to the provisions for a second medical opinion contained in section 58. See *B. v. Croydon Health Authority*, [1995] 1 All E.R. 683, [1995] 2 W.L.R. 294, [1995] 1 F.L.R. 470, [1995] 1 F.C.R. 662; *Re KB (adult) (mental patient: medical treatment)* (1994) 19 B.M.L.R. 144. See further, para. 20.19.1 above.

first administered during a period for which the patient is liable to be detained as a patient to whom Part IV applies. For example, if medication is administered to an informal patient or one who is detained under an application for emergency assessment or remanded for report, the three month period does not begin to run. Treatment takes place under those provisions only in accordance with ordinary common law requirements. The three months period commences once the patient has been detained under a section which falls within the scope of Part IV, for example, an admission for assessment or treatment (see para. 20.18 above). The question arises as to the interpretation of the phrase, “during a period for which he is liable to be detained”. Clearly if the authority for detention is broken by the patient’s discharge, a fresh period of three months begins when the patient is compulsorily admitted under a section within the scope of Part IV. If the patient is simply given a leave of absence or is transferred to another hospital, the three month period does not begin afresh, but continues to run. However, what is the position if a patient’s authority for detention is changed—for example, he is admitted for assessment and then, without being discharged, he is detained for treatment—or if the authority for detention is renewed (s. 20)? On one view, a “period for which he is liable to be detained” means that any change in the authority for detention indicates a fresh period of detention. Some support for this view is to be found in section 20 which refers to various “periods” of detention for patients admitted for treatment or subject to a hospital order. There is little doubt that Parliament did not intend for there to be a fresh period of “three months grace” each time the authority for detention was changed, so long as there was no break in the patient’s overall liability to detention. The three months rule represents a major deprivation of an ordinary common law right. The interpretation most favourable to the patient should prevail, and he should have the right to the safeguards provided in section 58 after three months unless there has been a clear break in his liability to detention under a section to which Part IV applies.¹ The phrase “since the first occasion in that period” means that the three months period commences as soon as medication is first administered during a relevant period. It does not matter whether the medication is given continuously or has been discontinued since it was first administered.

A question of some importance is, if a patient withdraws consent to medication, does the three month period commence when the treatment was first administered during a relevant period, or does it commence from the time the consent was withdrawn? This question is examined at paragraph 20.25.1 below.

The Code of Practice (para. 16.13) adopts the position most favorable to the patient’s right to receive a second opinion: “The three month

¹ This is the construction favoured by the DHSS (1983) *Mental Health Act 1983: Memorandum*, para. 195.

period is not affected by renewal of the detention order, withdrawal of consent, leave or change in or discontinuance of the treatment. A fresh period will only begin if there is a break in the patient's liability for detention."

20.21.3 Procedure for giving treatment under section 58

Subject to section 62 (which relates to treatment in an emergency; see para. 20.27 below) a patient cannot be given any of the treatments mentioned above (*i.e.*, medication after three months or ECT) unless **either** of the following requirements are met:

(i) **Consent**—There must be a certificate¹ in writing stating that the patient is capable of understanding the nature, purpose and likely effects of the treatment and has consented. The certificate can be made either by the responsible medical officer or a registered medical practitioner who is a member of, or appointed by, the Mental Health Act Commission (ss. 58(3)(a), 121(2)(a), (3)). Note that the patient must in fact consent. Competency to consent is a matter defined by the statute, but the other elements of consent (*e.g.* voluntariness) are still to be governed by the common law. (For a discussion of the statutory definition of competency and the information which should be given to the patient, see para. 20.20.3 above).

Or

(ii) **Appropriateness of the Treatment**—If the patient is incompetent to consent, or if he in fact does not consent, the treatment can be given by obtaining a written certificate² that, having regard to the likelihood of its alleviating or preventing a deterioration of his condition, the treatment should be given. The certificate can be given only by a registered medical practitioner appointed by, or a member of, the Mental Health Act Commission who cannot be the responsible medical officer (ss. 58(3)(b), 121(2), (3)). However, before giving a certificate the independent doctor must consult two other persons who have been professionally concerned with the patient's medical treatment, one of whom must be a nurse and the other neither a nurse nor a doctor. "Consultation" suggests a meaningful exchange of information and views, but the independent doctor is not obliged to follow the opinion of the professionals he consults. The people whom he consults are likely to be on the multi disciplinary team of the hospital and should have first-hand involvement in treating and/or caring for the particular patient such as a social worker, psychologist, occupational or other therapist.

¹ The certificate must be in the form specified (s. 64(2), reg. 16(2)(b), form 38).

² The certificate must be in the form specified (s. 64(2), reg. 16(2)(b), form 39).

20.21.4 Commentary

Section 58 represents a fundamental departure from traditional common law principles of self-determination. It specifies circumstances where treatment can be administered to a patient who is competent, but who refuses to consent.¹

20.22 Appointment of Doctors and Others to Certify Consent and Give Second Opinions

The Mental Health Act Commission (see paras. 22.02–22.14 *post*) must, on behalf of the Secretary of State, appoint registered medical practitioners for the purpose of Part IV (consent to treatment) and section 118 (doctors required to certify consent and to give a second opinion) of the Act.² All of the psychiatric members of the Commission have been appointed to give second opinions. The Commission has also appointed some ninety psychiatrists from outside the Commission to provide second opinions.

The Commission must also appoint other persons (not being doctors), for the purposes of section 57(2)(a) of the Act (persons required to certify consent). See further para. 20.20.3 above (s. 121(2)(a)). The Commission has appointed all of its non-medical members for these purposes.

By section 121(3) of the Act, the registered medical practitioners or other persons which the Commission must appoint may either be members of the Commission or non-members.

20.22.1 Second Opinion Appointed Doctor (SOAD)

The Second Opinion Appointed Doctor (SOAD) provides an independent safeguard of the rights of patients. The SOAD must personally interview the patient to determine if he is competent to give a valid consent and whether the treatment proposed is likely to be efficacious, without disproportionate adverse effects. The patient's reasons for withholding consent should be given due weight.

The SOAD makes an individual judgement based upon his own medical assessment, the prevailing standards of professional care, and the views of the RMO and members of multidisciplinary team. The SOAD should have available a full range of information and professional opinion about the patient's mental disorder, the treatment alternatives and their likely benefits and risks, and the patient's behaviour and social situation. The SOAD must sign Form 39 before

¹ See Gostin (1982) Compulsory Treatment in Psychiatry: Some Reflections on Self-Determination, Patient Competency and Professional Expertise, *Poly. L. Rev.*, vol. 7, p. 86.

² See further paras. 20.20.3, 20.20.5 and 20.21.3 above.

treatment may be given without consent. He may direct that a review report be sent from the Commission at a date earlier than the next date for review under section 61 (para. 20.26 below).

20.22.2 *Responsible medical officer*

The Code of Practice (paras. 16.23–16.37) emphasises that the RMO, managers, and statutory “consultees” each have responsibilities in ensuring a productive and fair visit by the SOAD. The RMO has a duty to ensure that the request for a visit of a SOAD is made, and that arrangements are made with the Commission. The RMO should speak with the SOAD personally, and make available all the relevant case notes and treatment proposals.

20.22.3 *Hospital managers*

The hospital managers should provide the SOAD with all the statutory documents including the forms for detention and make available all relevant professionals concerned with the patient’s care and treatment. A system should be in place to remind the RMO prior to the expiry of the limit set by section 58 and 61, and for checking the doctor’s response; and to remind the patient at the expiry of the three month period that his consent or a second opinion is required.

20.22.4 *Statutory “consultees”*

The SOAD has a statutory duty to consult a qualified nurse who has been professionally concerned with the patient’s care (not a nursing assistant, auxiliary or aide); and a person similarly concerned who is neither a nurse nor a doctor. Appropriate professionals under this later category would be a social worker, occupational therapist, psychologist, or psychotherapist, but not a student nurse, nursing aide, auxiliary or assistant.

Statutory consultees should be met in private and their views seriously considered. The consultee should discuss the proposed treatment, competency, consent, treatment alternatives, the decision making process, behaviours, views of the patient and relatives, and any other relevant matter. Consultees should record their conversation with the SOAD on the patient’s records.

20.23 Visiting Patients and Inspection of Records

Persons appointed by the Secretary of State for the purposes of Part IV and section 118 (see preceding para.) may, at any reasonable time, visit and interview and, in the case of a doctor, examine the patient in private. They may also require the production of and inspect

any records relating to the patient's treatment (ss. 119(2)), 129(1)(b)).¹ (See further para. 22.12 *post*).

20.24 Plans of Treatment

Any consent or certificate given under section 57 or 58 above can apply to a single form of treatment or to a plan of treatment (s. 59). There is scope for a great deal of flexibility and variation in the way a plan of treatment is framed: it can include several forms of treatment; it can specify the circumstances in which a particular treatment can be given (*e.g.*, the dosage of medication); and it can set a time limit on the duration of the treatment programme. If treatment is to be administered outside of the terms of the plan of treatment, the relevant statutory procedures of section 57 or 58 must be followed afresh. The plan of treatment has the advantages of flexibility and that careful thought can be given to a coherent programme of treatment on an individual basis. It also allows the responsible medical officer to carry out a diverse treatment programme without the need to obtain a second opinion for each aspect of that programme. On the other hand it creates a potential for misuse, with the doctor having wide scope to treat the patient without consent. It is suggested that certificates authorising treatments or a plan of treatment should be reasonably objective and narrowly drawn, with clear time tables for achieving the therapeutic goals.

20.25 Withdrawal of Consent

A patient may (subject to section 62 which applies to treatment in an emergency; see para. 20.27 below) at any time withdraw his consent to a specific treatment, to any plan of treatment, or to any specific aspect of a treatment plan (s. 60). This is merely a statutory ratification of a well established common law principle (see para. 20.11 above). It does not matter that the patient has signed a written consent form. He is entitled to withdraw consent either in writing, orally or by his behaviour. For example, if the patient, having signed a consent form to receive a treatment, physically resists the procedure, that should be taken as an implicit withdrawal of consent to that treatment. If the patient withdraws his consent to a treatment specified in section 57 or 58, it must cease immediately. If the treatment is psychosurgery or sex hormone implant treatment, it cannot be given. If it is medication or ECT then section 58 applies as if the remainder of the treatment were a separate form of treatment. Thus, if the treatment were ECT, a second opinion under section 58 would have to be obtained before administering it. (As to medication see para. 20.25.1 below). Even though a patient has withdrawn consent, the treatment may still be

¹ See also National Health Service Act 1977, s. 17; HC(83)19.

continued, pending compliance with section 57 or 58 if discontinuing the treatment would cause serious suffering to the patient (s. 62(2)).

20.25.1 *Withdrawal of consent to medication*

By section 58(1)(b) a medical certificate under section 58 is not required until “three months or more have elapsed since the first occasion in that period when medication was administered to him by any means for his mental disorder”. (See “the three months rule” discussed at para. 20.21.2 above). The question arises whether the three months rule would commence from the time the medication was first given, or from the time the consent was withdrawn. There are two possible constructions. The first is that, once a patient withdraws his consent to medication, a fresh period of three months would apply. This follows from section 60(1) where it provides that the effect of a withdrawal of consent is that the remainder of the treatment should be regarded as “a separate form of treatment”. This suggests that medication is deemed to be given afresh and a new three months period commences.

The second view best effectuates the right of the patient to a second opinion. The language of section 58(1)(b) indicates Parliament’s intention that the three month period should commence after “the first occasion when medication was administered to him by any means for his mental disorder”. This is widely drafted to ensure that the three month period begins to run irrespective of whether or not the patient has consented. The three month rule already applied before consent was withdrawn and it would be unfair if a new period of three months had to elapse before a second opinion was required.

Judging from the widely drafted language of section 58(1)(b) it appears that Parliament actually intended that only one period of three months should apply; this is the view taken by the Mental Health Act Commission. The language of section 60(1) (“... the remainder of the treatment [should be regarded as] a separate form of treatment”) is ambiguous and will require guidance from the courts.

20.26 **Review of Treatment**

It has already been suggested that the wiser course is to give a certificate with a limit of time. However, the statute does not require this, and “it would be theoretically possible as a matter of law for someone to obtain an open-ended second opinion”.¹ Thus, a treatment could in theory be continued indefinitely without the patient having the right to a further second opinion or independent monitoring of therapeutic progress. As a result of this concern, the Act makes provision for a continuing review of all treatments given under section

¹ K. Clarke (1982) *Official Report of the House of Commons Standing Committee*.

57(2) or 58(3)(b), *i.e.* where a treatment plan has been authorised by a doctor appointed by the Mental Health Act Commission. A report is not required when the treatment has been given after the R.M.O. has certified that the patient is capable of understanding the nature, purpose and likely effects of the treatment, and has consented to it.

The responsible medical officer must furnish a report to the Commission (see s. 121(2)(b)) on the treatment and the patient's condition (*i.e.*, his response to the treatment including whether he has improved or whether there have been adverse effects). The report must be made on the next occasion when the RMO furnishes a report to the hospital managers for the purposes of renewing the authority to detain a non-restricted patient under section 20(3) (see para. **11.06.5** *ante*), (s. 61(1)). It is likely the Commission will require more frequent reviews if the treatment has special risks, if it is particularly difficult to predict its effect on the patient, or if there are other special factors which require careful monitoring. If the patient is subject to a restriction order or restriction direction the report must be made: (i) if the treatment began within six months of the making of the order or direction, at the end of that six month period; (ii) if the treatment began any time after the first six months of the order or direction, at the next time when the responsible medical officer makes his annual report to the Home Secretary under section 41(6) or 49(3) (see para. **15.19** *ante*); (iii) and at any time specified by the the Commission (s. 61(2)).

When a report has been given to the Commission, required in section 61, permission for continued treatment may be assumed unless the Commission gives notice of withdrawal of permission¹. The Commission is empowered to give notice to the responsible medical officer that, after a specified date, the certificate will have no effect. In that case treatment can no longer be given unless requirements of section 57 or 58 are completed afresh. However, under the emergency provisions (s. 62(2)), treatment can be continued pending compliance with section 57 or 58 if discontinuance of the treatment would cause serious suffering to the patient. It is clear that urgent treatment cannot be given for an extended period of time, but only during the time when the statutory procedures under section 57 or 58 are being followed. (See following para.).

The Code of Practice (para. 16.21b) specifies that a review by the Commission must take place when the Second Opinion Appointed Doctor (SOAD) has time limited his certificate or made his certificate conditional upon making a review report on the treatment at a date earlier than the first statutory review (see MHAC 1).

¹ Mental Health Act Commission, Memorandum from the Chairman, September 1984, with accompanying form MHAC/1.

20.27 Urgent Treatment

Any treatment can be given without the need to comply with section 57 or 58 (*i.e.*, without the patient's consent or a second opinion) if the treatment is urgent (s. 62). Urgent treatment is defined as treatment which is:

- (a) immediately necessary to save the patient's life; or
- (b) (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition; or
- (c) (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or
- (d) (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.

Section 62 operates only in urgent situations where treatment is *immediately necessary*; treatment without consent or a second opinion cannot be justified simply because it is necessary or would be beneficial. Urgent treatment cannot be continued beyond the point at which the emergency has been brought to an end, and the usual safeguards provided under section 57 or 58 should then be observed.

The definition of urgent treatment means that, in certain circumstances, treatments which are irreversible or hazardous cannot be administered without the appropriate consent and/or a second opinion, even if they are immediately necessary. The Act defines the terms "irreversible" and "hazardous" in a somewhat circular fashion: "treatment is irreversible if it has unfavourable irreversible physical or psychological consequences and hazardous if it entails significant physical hazard" (s. 62(3)). A decision as to whether a particular treatment is irreversible or hazardous is, in the first instance, a matter for the responsible medical officer. However, the RMO must make decisions which are reasonable and within the mainstream of contemporary medical thought. The Mental Health Act Commission could give guidance in this area, for example, in the code of practice (s. 118(1)(b)). It is to be expected, for example, that psychosurgery would be regarded as irreversible and unmodified ECT would be regarded as hazardous.

If a patient withdraws his consent to a treatment (see para. 20.25 above), or if the Mental Health Act Commission withdraws a certificate under section 61(3) (see para. 20.26 above), the treatment can still continue if the responsible medical officer considers that discontinuance would cause serious suffering to the patient (s. 62(2)).

The scope of the emergency provisions in section 62 is wider than that of the doctrine of necessity in common law (see para. 20.16 above).

It is, therefore, important to recognise that section 62 only modifies sections 57 and 58, and applies to no other treatments. Thus, section 62 is applicable only to cases which come within the remit of section 57 or 58. Section 62 would not, for example, justify treatment for a physical illness even if it were immediately necessary; nor would it apply to any treatment given to a patient to whom Part IV does not apply (see paras. **20.18–20.19** above). Recourse to ordinary common law principles is necessary in such cases.

The managers should provide a form for the RMO to complete every time urgent treatment is administered under section 62. (Code of Practice, para. 16.19)

20.28 Treatment Not Requiring Consent

Any medical treatment for mental disorder given by or under the direction of the responsible medical officer to a patient to whom Part IV applies can be administered without the consent of the patient if the treatment is not listed in section 57 or 58, the regulations or the code of practice (s. 63). Thus, the consent of any detained patient falling within the scope of Part IV is not required for psychiatric treatments not regulated by section 57 or 58. This is a sweeping statutory provision, for it removes the traditional common law right of an individual to self-determination, irrespective of the patient's competency.

The Code of Practice (paras 16.16–16.17) clearly regards the process of obtaining consent as important to the therapeutic relationship. The Code acknowledges that a wide range of treatments (particularly psychological, social, and behavioural) may be given without consent. However, the effectiveness of these treatments requires a clear expression of agreement and voluntary co-operation (as opposed to passive submission) by the patient.

D. RIGHT TO TREATMENT UNDER THE EUROPEAN CONVENTION OF HUMAN RIGHTS

20.29 Article 5(1) Protects Only the Right to Liberty and Not the Right to Treatment

Article 5(1) of the European Convention on Human Rights provides that: "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. Sub-paragraph (e) justifies the deprivation of persons on the ground of "unsoundness of mind."¹ The question arises whether a person's liberty can be deprived on the ground that he is of unsound mind without providing minimally adequate treatment to help ameliorate his mental condition.

In *Ashingdane v. the United Kingdom*² (as to the facts, see para. 21.29.2 *post*) the European Commission and Court of Human Rights considered whether Article 5(1)(e) encompassed not only actual detention but also the treatment of the patient including the nature of, and conditions in, the detaining institution. The facts of *Ashingdane's* case showed that his continued detention under conditions of security actually was causing a deterioration in his mental health. The Commission, following the judgment in *Winterwerp's* case,³ found that, in principle, Article 5(1) is concerned with the question of the actual deprivation of liberty of mental patients and not their treatment. Other provisions of the Convention, such as Article 3 (inhuman and degrading treatment) and Article 18 (the prohibition on using permitted Convention restrictions for ulterior purposes) might be an issue were a patient to be incarcerated in appalling conditions with no consideration being given to his treatment.

The European Court recognised that the term "lawfulness" under Article 5(1) referred both to the ordering of detention and its execution. Such "lawfulness" requires conformity with the domestic law **and** with the purposes of deprivation of liberty permitted by Article 5(1). If detention is ordered arbitrarily it cannot be lawful. Further there must be some relationship between the ground of permitted deprivation of liberty relied upon and the place and conditions of detention. In principle, the "detention" of a person of "unsound mind" is lawful for the purposes of Article 5(1)(e) only if effected in a hospital, clinic or an appropriate therapeutic institution. Thus the **purpose** of the detention must be related to the person's mental disorder. Apart from this very basic requirement, Article 5(1)(e) does not require any examination of

¹ See Gostin (1982) Human Rights, Judicial Review and the Mentally Disordered Offender. *Crim. L. Rev.*, pp. 779-793.

² Report of the European Commission of Human Rights adopted on May 12, 1983. Judgment of the European Court of Human Rights, May 28, 1985.

³ Judgment of the European Court of Human Rights on October 24, 1979.

the execution of detention such as minimally adequate treatment, or the environment and conditions of detention.

The European Commission of Human Rights in *Winterwerp* and *Ashingdane* has gone a long way towards preventing any "right to minimally adequate treatment" claim to be put forward under Article 5. The Commission sees a distinct separation between legitimate detention under Article 5 on grounds of unsoundness of mind and the question of whether there is any reasonable attempt to provide the requisite treatment and care. The Commission's view is disappointing. Minimally adequate treatment and care should be a necessary pre-condition to detention on the grounds of unsoundness of mind; otherwise it would be difficult to justify detention on those grounds alone. Put another way, if the government is to deprive a person of liberty not on the grounds of dangerous behaviour but because of the person's need for treatment, then it must be incumbent upon the government to provide a minimally adequate standard of treatment so that a person's mental health does not deteriorate, but can actually improve. (Compare the approach of the European Commission with that taken by the United States Supreme Court in *O'Connor v. Donaldson*¹ where the question of minimally adequate treatment was linked with detention of non-dangerous patients.)

20.29A Article 3 Prohibits Inhuman and Degrading Treatment

Article 3 of the European Convention on Human Rights and Fundamental Freedoms provides that "no one shall be subjected to torture or to inhuman or degrading treatment or punishment". The European Commission or Court of Human Rights has never found on the merits that the conditions in a mental hospital were so inhuman and degrading as to breach Article 3 of the European Convention. Yet, severe maltreatment, neglect or humiliation of patients could give rise to a claim under Article 3.

In *B. v. the United Kingdom*² the applicant, a patient at Broadmoor Hospital, complained that he was detained in grossly overcrowded conditions, lacking in adequate sanitary (e.g. toilet and washing) facilities, and in a constant atmosphere of violence. He alleged that dormitory beds were only six to twelve inches apart, that observation lights were kept on all night, and there was no privacy and little fresh air or exercise. The applicant claimed he had received no treatment whatsoever and almost never saw his doctor.

The European Commission determined his complaint to be admissible for the following reasons.

¹ 422 U.S. 563 (1975).

² Application No. 6870/75. Second partial decision of the Commission as to admissibility, 12 & 14 May 1977. See also L. Gostin (April 1978) Observations on the merits of Application No. 6780/75 under Article 3 of the European Convention on Human Rights, MIND, London.

“The physical conditions in Broadmoor Hospital are admittedly unsatisfactory and have been criticised by different official bodies over a number of years. While the hospital staff may . . . do their best to cope with these inadequacies, this does not exclude the possibility that the physical conditions of detention could in themselves give rise to a question under Article 3. The Commission considers that the applicant’s different allegations concerning the conditions of his detention and the question of his medical treatment must be looked at together and, if so examined, raise issues under Article 3 which require investigation and examination on the merits”.

The Commission subsequently ruled against the applicant on the merits because of the absence of a single incident which was so grave as to warrant a finding of inhuman and degrading treatment. The Commission’s decision leaves in doubt whether Article 3 would take cognizance of the totality of conditions in the absence of a single factor which was so gross as to shock the conscience. (As to the Application of Article 3 to seclusion in a special hospital see para. 3.12A *ante*; as to the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment Punishment, see para. 20.29B below).

In *Herczegfalvy v. Austria*¹ the question was raised of whether medical treatment could amount to inhuman and degrading treatment. On admission to the psychiatric hospital in September 1979 the applicant was in a weakened state following a hunger strike. On this and the several subsequent occasions when he resumed his hunger strike, he was force fed pursuant to the Austrian Hospitals Law, and was given strong doses of sedatives against his will. He was also at different times attached to a security bed by a net and straps and was handcuffed and a belt placed around his ankles because of his aggressive and threatening behaviour. He complained that his treatment breached Articles 3 and 8 of the European Convention. The Strasbourg Court held that “the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it was for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves, such patients nevertheless remain under the protection of Article 3, whose requirements permitted of no derogation.” The Court then went on to rule that the established principles of medicine were admittedly in principle decisive in such cases, and, as a general rule, a measure which was a therapeutic necessity could not be regarded as inhuman or degrading. Nevertheless, the Court had to satisfy itself that the medical necessity had been convincingly shown to exist. Although the Court found worrying the prolonged use of handcuffs and the security bed, the evidence before it was

¹ (1993) 15 E.H.R.R. 437; (1992) 18 B.M.L.R. 48.

insufficient to disprove the Government's argument that, according to the psychiatric principles generally accepted at the time, medical necessity justified the patient's treatment. Therefore there had been no violation of Article 3. Mr Herczegfalvy further alleged that, by forcibly feeding and medicating him, the authorities had violated his right of privacy under Article 8 of the Convention. Here the Court noted that this complaint involved the same subject matter as the complaint under Article 3, and attached decisive weight to the lack of specific information capable of disproving the Government's opinion that the hospital authorities were entitled to treat the applicant's psychiatric illness as rendering him entirely incapable of taking decisions for himself. No violation of Article 8 had therefore been shown in this respect.

20.29B European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment

The European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment was signed by the Government of the United Kingdom. The intention of the Convention is to strengthen the protection of persons deprived of their liberty by non-judicial means of a preventive character based on visits.

The Convention provides for the establishment of a European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. The Committee examines the treatment of persons deprived of their liberty by making visits to places where persons are deprived of their liberty by a public authority, including prisons and hospitals (especially special hospitals and regional secure units where virtually all patients are subject to detention). The Committee, in cooperation with member states, organises its own visits, carried out by at least two members with the assistance of experts and interpreters. In addition to periodic visits, the Committee may organise such other visits as appear to it to be required in the circumstances. The Committee must notify the Government concerned of its intention to carry out a visit, after which it can visit at any time.

The Government must provide the Committee with unlimited access to the place of detention, full information necessary to carry out the task, including the right to interview detained persons in private, and the right to communicate freely with any relevant person.

The government may make representations to the Committee against a visit. This can occur only in exceptional circumstances on grounds of national defence, public safety, serious disorder in places where persons are deprived of their liberty, the medical condition of a person, or that an urgent interrogation to a serious crime is in progress.

After each visit, the Committee must draw up a report on the facts found, and transmit its report to the Government with any recommendations. If the Government fails to cooperate or refuses to improve the

situation, the Committee may decide by a majority of two-thirds of its members to make a public statement on the matter.

The Committee's report is confidential, but can be published whenever requested by the Government. However, no personal data can be published without the express consent of the person concerned. Subject to these rules of confidentiality, the Committee must submit a public report to the Committee of Ministers annually.

E. CONFIDENTIALITY

20.30 Professional Responsibility

20.30.1 *Background*

In medicine there is a long established principle of confidentiality first referred to in the Hippocratic Oath 3000 years ago: "And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets." This century the undertaking is repeated in the Declaration of Geneva: "I will respect the secrets which are confided in me, even after the patient has died."

Rule 80 of the General Medical Council advice provides that, except in circumstances specified in Rule 81, it is a doctor's duty "strictly to observe the rule of professional secrecy by refraining from disclosing voluntarily to any third party information about a patient which he has learnt directly or indirectly in his professional capacity."¹

20.30.2 *Definition of 'confidence'*

The word confidence is derived from the classical latin "confidentia" and has retained in modern English the same basic meaning described in the Concise Oxford Dictionary as "the mental attitude of trusting in and relying on a person or thing; firm trust, reliance, faith, thus to "the confiding of private or secret matters to another". The placing and receiving of personal confidence either presupposes the existence of a responsible relationship between the participants, or the act of confiding itself generates such a relationship. It has been long accepted that counsel may be sought from the professional—the priest, the doctor, the lawyer—and that the consultation will be secret, except insofar as the counsel-seeker consents to the use of the material of confidence.

¹ Advice and Standards of Professional Conduct and of Medical Ethics, GMC "Blue Book" on Professional Conduct and Discipline. A disclosure compelled by statute or court order is not voluntary. The exceptions listed in Rule 81 include: (a) if the patient gives valid consent; (b) sharing with other professionals responsible for clinical care; (c) giving information in narrow circumstances to a close relative; (d) in exceptional circumstances to serve the patient's best interests; (d) statutory reporting requirements; (f) a court order; (g) rarely, in the public interest to prevent a serious harm; (h) medical research.

20.30.3 *Extended Confidence*

Frequently the needs of the client cannot be met by one professional and the concept of "extended confidence" will apply. Thus a communication made to one professional (*e.g.* a psychiatrist or psychotherapist) may be shared with the multi-disciplinary team (*e.g.* social worker, nurse, psychologist and occupational therapist); each member of the team (and those who provide administrative and secretarial support) have a professional and ethical obligation to treat the information as confidential.

20.31 **Ownership of Medical Records**

The Department of Health's view, which does not have the force of law, was set out by Dr Gerald Vaughan in a statement to Parliament on May 6, 1980:

"Medical records are maintained by doctors for the purpose of the treatment and care of their patients. Safeguarding the confidentiality of such records is primarily an ethical matter for the doctors concerned. The use of identifiable information from medical records for the purposes other than that for which it was obtained—except when ordered by a Court or pursuant to a statutory requirement—would require the agreement of the doctors concerned, who would decide as an ethical matter whether the consent of the patient should be sought. I would not wish the technicality of legal ownership of medical records by the Secretary of State, or custody of medical records by health authorities, to be used to circumscribe (*sic*) the ethical responsibility of doctors for confidentiality in relation to their patients".

Clearly the Department of Health sees the fact of ownership of medical records by the National Health Service as posing an impediment in legally enforcing the confidentiality of those records. By this reasoning patients do not own their records and, therefore, have no legal right to see them or to determine who they can and cannot be shown to. But the law of confidence does not turn solely upon questions of ownership (see next para.).

The Access to Medical Reports Act 1988 establishes a right of access by individuals to medical reports relating to themselves for employment or insurance purposes. But a doctor need not allow access when disclosure would be likely to cause serious harm to the physical or mental health of the individual or others or would indicate the intentions of the practitioner with respect to that individual.

20.32 **The Law of Confidence**

20.32.1 *Introduction*

There exists an action at common law, independent of statute, for breach of confidence. Generally speaking, it is a civil remedy affording protection against the disclosure or use of information which is not

publicly known and which has been entrusted to a person in circumstances imposing an obligation not to disclose or use that information without the authority of the person who imparted it.¹ However there is uncertainty as to the nature and scope of the remedy owing to its obscure legal basis.² (As to proposals for reform see para. 20.33 below). In particular most of the decided cases concern commercial or financial interests³ and few have concerned breach of confidential information of a personal nature such as in a therapeutic or social work relationship.⁴

The major exception is the case of *W. v. Egdell*⁵ where Mr. Justice Scott examined the psychiatrists' duty of confidence. A restricted patient obtained an independent psychiatric report for the purposes of a Mental Health Review Tribunal application. The report was unfavourable, suggesting that the patient had a "psychopathic deviant personality" and that he might be dangerous. The patient decided to withdraw his application to the tribunal, without disclosing the report to the hospital or Home Secretary. The independent psychiatrist sent a copy of his report to the hospital and requested that a copy be sent to the Home Office.

The patient then sought an injunction against use or disclosure of the doctor's report and delivery up of all copies. The patient claimed that the doctor had a duty of confidence based upon both an equitable obligation and a legal privilege. Damages were also sought for the "shock and distress" to the patient from the unauthorised disclosure.

Mr. Justice Scott held that the duty of confidence owed by psychiatrists to patients detained under the Mental Health Act was less extensive than that owed to ordinary members of the public. In this case the independent psychiatrist did owe the patient a duty of confidence, but that duty did not extend so far as to bar disclosure of the report to the hospital or to the Home Office.

The limitation on confidentiality was justified "by the needs of the hospital in charge of 'clinical management', and the need of the Home Secretary . . . and of the tribunal to be fully informed about the patient." In particular, Mr. Justice Scott gave two reasons for the decision which are important in understanding the boundaries set on the duty of confidence. First, confidences could be disclosed where the "public interest overrode the duty to the patient". The duty of confidence was both created and circumscribed by the particular circum-

¹ See, e.g. *Saltman Engineering Co. Ltd., v. Campbell Engineering Co. Ltd.* (1948) 65 R.P.C. 203; [1963] 3 All E.R. 413.

² See G. Jones (1970) *Restriction of Benefits Obtained in Breach of Another's Confidence*, 86 *L.Q.R.* 463.

³ For a review of the early cases see the Law Commission (1981) *Breach of Confidence*, Law. Com., No. 110, Cmnd. 8388, paras. 3.1-3.16.

⁴ But see *Wyatt v. Wilson* (1820) cited in *Prince Albert v. Strange* (1849) 1 Mac. & G. 25, 26: "if one of the late Kings physicians' had kept a diary of what he heard and saw, this court would not in the King's lifetime, have permitted him to print and publish it."

⁵ [1989] 2 W.L.R. 689; [1989] 1 All E.R. 1089; (1988) *The Times*, December 14, 1988. Chancery Division: Scott J.

stances of the case. In this case, where the patient had been convicted of grave offences, the doctor owed a duty not only to the patient but also to the public. This required him to place before the proper authorities the results of his examination.

Second, the duty of confidence imposed on psychiatrists was the same whether they came within a hospital regime or were independent. The patient had been seen by a number of psychiatrists each of whom owed him a duty of confidence: none would have been entitled to sell the information to a newspaper or make general disclosure of it, but all their reports were on the patient's file and available to the Home Office.

The Court of Appeal upheld the decision of Mr. Justice Scott in *Egdell*.¹ The Court balanced two competing public interests—the public interest in maintaining professional confidences, and the public interest in protecting the public safety. The balance came down decisively in favour of disclosure because the patient had a background involving serious violent crime, the decision regarding his release from a secure hospital should be well informed, and the information disclosed was highly relevant to the public safety.

The Court of Appeal affirmed that a doctor providing an independent medical opinion, just like any other doctor in a therapeutic relationship, has a duty to maintain the patient's confidences. This disclosure, however, came within Rule 81(g) of the General Medical Council's Advice on Standards of Professional Conduct and of Medical Ethics: "Rarely, disclosure may be justified on the ground that it is in the public interest which, in certain circumstances such as, for example, investigation by the police of a grave and very serious crime, might override the doctor's duty to maintain his patient's confidence."

Bingham LJ delineated the allowable exception to the duty of confidentiality:

"Where a man has committed multiple killings under the disability of serious mental illness, decisions which may lead directly or indirectly to his release from hospital should not be made unless a responsible authority is properly able to make an informed judgement that the risk of repetition is so small as to be acceptable. A consultant psychiatrist who becomes aware, even in the course of a confidential relationship, of information which leads him, in the exercise of what the court considers a sound professional judgement to fear that such decisions may be made on the basis of inadequate information and with a real risk of consequent danger to the public is entitled to take such steps as are reasonable in all the circumstances to communicate the grounds of his concern to the responsible authorities."

The Court of Appeal departed from Mr. Justice Scott's decision only

¹ *W. v. Egdell* [1990] 1 All E.R. 835, [1990] 2 W.L.R. 471 C.A.

in a few material respects. First, the Court of Appeal rejected the trial court's finding that Rule 81(b) of the GMC ethical advice was applicable to a case involving an independent medical report. Para (b) allows a doctor to share confidential information with other professionals responsible for the clinical management of the patient. That sub paragraph, said Bingham LJ, is directed toward the familiar situation in which a consultant or other specialist reports to the doctor with clinical responsibility or other persons in the multidisciplinary team. Dr. Egdell was not primarily motivated by the ordinary concern of a doctor that a patient should receive the best possible treatment.

Second, Mr. Justice Scott was wrong to regard the duty of confidence as a private duty owed to the patient. In fact, the duty of confidentiality is based upon a broader ground of public interest.¹

The House of Lords in the *Spycatcher*² case held that "although the basis of the law's protection of confidence is that there is a public interest that confidences should be preserved and protected by law, nevertheless that public interest may be outweighed by some other countervailing public interest that favours disclosure . . . [This] may require the court to carry out a balancing operation, weighing the public interest in maintaining confidence against a countervailing public interest favouring disclosure."

Third, Mr. Justice Scott was wrong to suggest that patients with mental illness or those in secure hospitals enjoy rights to confidentiality less extensive than those enjoyed by other members of the public. The standard for breach of confidentiality in Rule 81(g) is equally applicable to all patients.

The Court of Appeal in *R. v. Crozier*³ affirmed the decision in *Egdell*. The appellant was remanded in custody where he was seen by two psychiatrists, both instructed by his solicitor to interview and report on the appellant. The first psychiatrist, Dr. Wright, concluded the appellant was not mentally ill. The second psychiatrist, Dr. McDonald, produced a report recommending his admission to Broadmoor Hospital, but the report was not available in time for the hearing. The judge, accordingly, sentenced the appellant to imprisonment. Having heard the judge's sentence Dr. McDonald disclosed his report to counsel for the Crown, together with information that Dr. Wright had changed his mind and would recommend a hospital order. The judge, relying on these two opinions, later varied the sentence to a hospital order with restrictions on discharge. The appellant urged the judge not to substitute a hospital order, claiming that the report should not have been submitted to the Crown because it was confidential. The appellant

¹ See *X. v. Y.* [1988] 2 All E.R. 648, Rose J.

² *A-G v. Guardian Newspapers Ltd (No. 2)* [1988] 3 All E.R. 545.

³ [1991] Crim. L. Rev. 138 (Transcript: Marten Walsh Cherer) 11 April 1990.

argued that he was entitled to receive the report and to decide whether to introduce it into evidence.

The Court of Appeal applied the test in *Egdell* in upholding the new sentence of the judge. Watkins LJ said that “Dr. McDonald was firmly of the opinion that the appellant suffers from a psychopathic disorder, continues to be a danger to the public and should be kept in a special secure hospital without limit of time. He held this opinion so strongly that he felt impelled to ensure that the court became aware of it.”

The “strong public interest in disclosure” in *Crozier* was founded upon the following elements: a patient who had a history of serious danger to others, a firm belief on the part of the psychiatrist that he posed a prospective danger to others, and the psychiatrist disclosed highly relevant information designed to avert the danger.¹

The Court of Appeal in *Egdell* and *Crozier* left unclear the precise nature and scope of the duty of confidentiality and the right to disclose information, premised upon the danger to the public. Certainly, an independent psychiatrist, as well as a hospital psychiatrist, “could not lawfully sell the contents of his report to a newspaper, . . . or discuss the case in a learned article or in his memoirs or in gossiping with his friends, unless he took appropriate steps to conceal the identity” of his patient.² However, psychiatrists are entitled to make relevant information about a seriously dangerous patient available to the hospital, other members of the therapeutic team, to health authorities and, in the case of restricted patients, to the Home Office.

Egdell and *Crozier* could be read narrowly to justify disclosure only in the circumstances arising in these cases—patients with serious criminal backgrounds and a strong belief on the part of the doctor that the patient poses a danger to the public. Yet the Court of Appeal provided little guidance as to the extent of the exception to the rule of confidentiality, say, in cases where the patient does not have a history of serious violence. Must the prospective harm be real, immediate, and serious? Must there be identifiable third persons at risk of harm? Must disclosure significantly reduce the risk of harm? Must disclosure be limited to particular information necessary to avert the harm? Is the damage to the public interest protected by the duty of confidentiality outweighed by the public interest in protecting third persons

A justifiable rule for the future might protect confidentiality as a compelling public purpose in that it safeguards the trust of a doctor-patient relationship and allows the patient to confide his most intimate thoughts. Taking the principle of confidentiality seriously ultimately serves the interests of both the patient and the public. It serves the patient's interests because it encourages him or her to come forward

¹ The Court did not address the issue of how the disclosure would avert a foreseeable danger, since the appellant was, in any case, sentenced to a long term of imprisonment.

² *W. v. Egdell* [1990] 1 All E.R. 835, per Bingham LJ.

for treatment; and it protects the public in that patients are more likely to confide their violent tendency to their doctor. The compelling public purpose in confidentiality could be overridden only where a doctor had reasonable grounds for believing that an immediate and serious harm would occur in the absence of the disclosure.

The Court of Appeal also left unclear whether a doctor has a *power* to disclose which protects him against civil liability for breach of confidence; or whether he has a *duty* to disclose where failure to fulfill that duty might result in liability. In the United States, many states have followed the *Tarasoff* doctrine which places a duty on the health care professional to disclose confidences in order to avert a clear and immediate danger to an identifiable third party.¹

The patient argued in *W. v. Egdell* that the duty of confidentiality may be recognised in equity (para. 20.32.2), and perhaps even as a legal privilege (para 20.32.9). He also raised a question as to what, if any, damages are recoverable (para. 20.32.9). These issues were taken up by Mr. Justice Scott and are discussed below, although the Court of Appeal declined to consider them.

20.32.2 *Relationships in which information becomes impressed with the obligation of confidence*

An obligation of confidence may be created by contract, express or implied.² But there is also a body of case law where confidential relationships are formed irrespective of contract, and equity has recognised an obligation of confidence. A responsibility to hold information confidential will arise when the circumstances of the relationship impart it.³ If a patient or client has a private interview with a professional, whether doctor or social worker,⁴ and imparts personal information of an intimate nature, whether medical or social, then in the ordinary course of events there is a confidential relationship established; there is an implied understanding that the information will not be used except where it is needed in discussion with other professionals in furtherance of the service provided by the professional.

¹ *Tarasoff v. Regents of the University of California* (1976) 17 Cal 3d 358 (psychologist found liable for failing to warn his patient's girlfriend that he has made a serious and credible threat against her life. The patient killed his girlfriend and she had not been forewarned of the danger).

² See, e.g., *Ackroyds (London) Ltd. v. Islington Plastics Ltd.* [1962] R.P.C. 97.

³ See, e.g. *Attorney-General v. Jonathan Cape Ltd* [1976] Q.B. 752.

⁴ The doctor is a professional controlled by the General Medical Council established by Act of Parliament; the profession also has a longer and more established history which might well lead the patient to assume the confidentiality of personal information which is imparted. But there is no reason in principle to assume that the same kind of confidential relationship could not be established in respect of other professional groups such as social workers. It is suggested that the true test would be the extent to which the parties could reasonably assume the existence of a confidential relationship.

The concept of a confidential relationship where a doctor-patient relationship is formed is important. If the patient knows, or reasonably should know, that the purpose of the interview is not diagnosis or treatment in his best interests, but for some non-therapeutic purpose, the patient may have no expectation of, or right to, confidentiality. Bingham LJ in *W. v. Egdell*¹ explained that the breath of the duty of confidentiality is dependent upon the circumstances:

“Where a prison doctor examines a remand prisoner to determine his fitness to plead or a proposer for life insurance is examined by a doctor nominated by the insurance company or a personal injury plaintiff attends on the defendant’s medical adviser or a prospective bidder instructs accountants to investigate (with consent) the books of a target company, the professional man’s duty of confidence towards the subject of his examination plainly does not bar disclosure of his findings to the party at whose instance he was appointed to make his examination.”

The Court of Appeal, however, in both *Egdell* and *Crozier*² made clear that the duty of confidentiality does apply to an independent psychiatrist instructed by the patient to prepare a report on his behalf. The psychiatrists in those cases should have appreciated that the patient has an expectation of privacy, and that his legal advisor could decide not to adduce the report in evidence.

20.32.3 *The parties to a confidential relationship*

A confidential relationship is usually between the person supplying the information and the person receiving it. Persons may also be in a relationship of confidence in respect of information discovered or acquired by one of them on behalf of the other.³ Thus the obligation of confidence owed by a professional covers not only information imparted by the patient or client but also to information relating to the patient or client which the professional secures from others. For example, personal information obtained by a GP about his patient from a psychiatrist or other specialist may be confidential. Further, any third party is liable to be restrained from disclosing or using information which he knows or ought to know was subject to an obligation of confidence.⁴

20.32.4 *Is negligent disclosure of information actionable?*

There may be liability for breach of confidence if the holder of confidential information in fact discloses or uses it, even if he is not

¹ [1990] 1 All E.R. 835.

² *R. v. Crozier* [1991] Crim. L. Rev. 138.

³ See *Cranleigh Precision Engineering Ltd. v. Bryant* [1966] R.P.C. 81; [1965] 1 W.L.R. 1293.

⁴ *Duchess of Argyll v. Duke of Argyll* [1967] Ch. 302.

consciously aware of doing so.¹ Where the parties are in a contractual relationship there is liability if the information is disclosed negligently.² But there is no clear answer whether there is liability in a non-contractual relationship where the confidant does not take reasonable care to keep information confidential—for example where a doctor or social worker carelessly leaves a patient's file in a place where it can be read by others.

20.32.5 *The information must be secret*

The information imparted, for it to have an obligation of confidence, must have “the necessary quality of confidence about it”. Thus the information itself must have a secret character in the sense that it is not something which is public property and public knowledge,³ *i.e.* that the information is not in the “public domain”. This does not mean that if other people may know the facts in question that an action for breach of confidence cannot succeed—if relative secrecy remains, the plaintiff can still succeed.⁴

20.32.6 *Where it is in the public interest to disclose information*

It appears to be a defence where it is in the public interest to disclose confidential information. The defence “extends to any misconduct of such a nature that it ought in the public interest to be disclosed to others . . . crimes, frauds and misdeeds, both those actually committed as well as those in contemplation. . . .”⁵

The Court of Appeal, in *W. v. Egdell*⁶ recognised a public interest exception to confidentiality in a case where an independent psychiatrist sought to inform the authorities of his expert opinion that a restricted patient was dangerous to the public (see para. 20.32.1 above).

Thus, if in the course of a confidential therapeutic relationship a patient discloses that he has or intends to commit a serious crime such as an assault, it appears the therapist is entitled to disclose the information to the police. In the United States, the California Supreme Court in a celebrated case went considerably further and decided that a therapist had a duty of care towards third parties who may be endangered by the therapist's patient; in particular the therapist may be under a **duty** “to warn the intended victim or others likely to apprise the

¹ *Seager v. Copydex Ltd.* [1967] R.P.C. 349; [1967] 1 W.L.R. 923.

² *Weld-Blundell v. Stephens* [1920] A.C. 956.

³ *Saltman Engineering Co Ltd. v. Campbell Engineering Co Ltd* (1948) 65 R.P.C. 203, 215, [1963] 3 All E.R. 413, 415. See *D. Mustad and Son v. Dosen* [1963] R.P.C. 41, 43; [1964] 1 W.L.R. 109, 111, H.L.

⁴ *Franchi v. Franchi* [1967] R.P.C. 149, 152–53.

⁵ *Initial Services Ltd v. Putterill* [1968] 1 Q.B. 396, 405, per Lord Denning M.R. See *Weld-Blundell v. Stephens* [1919] 1 K.B. 520, 527.

⁶ [1990] 1 All E.R. 835.

victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances".¹

20.32.7 Disclosure required by statute or by court order: discovery

It is a defence to an action for breach of confidence that disclosure or use of the information was required or authorised by statute or that disclosure was ordered by a court under powers attaching to its inherent jurisdiction such as its power to order discovery.

Documents such as psychiatric or social enquiry reports are not protected from discovery merely because the information which they contain was given in confidence.² Nevertheless the Court has discretion whether or not to order disclosure, and the confidentiality of the information is a very material consideration.³ The "ultimate test" is whether discovery is necessary for disposing fairly of the proceedings.⁴ This is to be weighed against the public policy considerations of disclosing confidential information.⁵

In *Gaznabbi v. Wandsworth Health Authority*⁶ a nurse at Springfield Hospital was summarily dismissed for making a lewd comment to a psychiatric patient. The issue for the Employment Appeal Tribunal was whether the patient's case notes should be discovered to the nurse, so that he could ascertain the general veracity and credibility of the patient. The EAT upheld the tribunal's decision not to order discovery because of the highly confidential nature of the case notes. The EAT adopted the principle in *Science Research Council v. Nasse*⁷ that when a court or tribunal "is impressed with the need to preserve confidentiality in a particular case, it will consider carefully whether the necessary information has been or can be obtained by other means, not involving a breach of confidence."

¹ *Tarasoff v. Regents of the University of California*. (1976) 17 Cal. 3d 452, 551 P. 2d. 334, 131 Cal Rptr. (1976) (*Tarasoff II*), *vacating* 13 Cal. 3d. 117, 529 P. 2d. 553, 118 Cal. Rptr. 129 (1974) (*Tarasoff I*). (A psychiatric out-patient successfully carried out his intention, previously confided to his psychotherapist, to kill a particular victim.) See D. Wexler (1979) Patients, Therapists, and Third Parties: The Victimological Virtues of *Tarasoff*, *Int'l. J. Law & Psychiat*, vol. 2 pp. 1-28.

² See *Chantrey Martin v. Martin* [1953] 2 Q.B. 286, 294.

³ See *Alfred Crompton Amusement Machines Ltd. v. Customs and Excise Commissioners* (No.2) [1974] A.C. 405.

⁴ *Science Research Council v. Nasse* and *Leyland Cars v. Vyas* [1980] A.C. 1028, 1065-66.

⁵ Compare *D. v. National Society for the Prevention of Cruelty to Children* [1978] A.C. 171 (House of Lords upheld right of NSPCC to oppose discovery of documents which might reveal the identity of a complainant) with *British Steel Corporation v. Granada Television* [1980] 3 W.L.R. 774 (House of Lords ordered disclosure of document held by Granada even though it would reveal the source).

⁶ Employment Appeal Tribunal, EAT/538/88 (Transcript) 15 November 1989.

⁷ [1980] AC 1028.

20.32.8 Privilege

In English law a doctor-patient, therapist-client or social worker-client relationship is not privileged. There is no immunity from the obligation of disclosing to the court confidential information obtained in the course any of these relationships.¹ Such confidential information may be subject to disclosure to the court at its discretion and governed by the criteria set out in the preceding paragraph.

The Court of Appeal in *R. v. McDonald*² affirmed that "no privilege of confidentiality attaches to communication between doctor and patient." In *McDonald* a psychiatrist engaged by the state to report on the defendant's mental condition gave evidence of factual matters unrelated to any medical opinion. Nevertheless the Court of Appeal said that the Crown should seek to adduce evidence of what a defendant said to a doctor when the issue being tried is non-medical only in exceptional circumstances.

There is, however, a solicitor-client privilege, and some litigants have sought to use the privilege to ensure confidentiality of communications between the solicitor and expert witnesses. The rule is that legal professional privilege attaches to confidential communications between solicitors and expert witnesses but not to documents upon which an expert based his opinion.³ Moreover, a distinction must be made between instructions given to experts (which are privileged) and the experts' opinion (which is not privileged).⁴ The courts, therefore, afford an exceedingly limited privilege to experts which appears to exclude any documents he refers to as well as his expert opinion based upon those documents. It is feasible that the privilege applicable in tribunals will be regarded as even more narrow than in the courts, because tribunals are not adversarial but inquisitorial.⁵

20.32.9 Remedies

The two main remedies of equitable origin for breach of confidence are the discretionary ones of declaration and injunction. Damages could be awarded in respect of information of a commercial character. But these established remedies are of very little use to the person who suffers from mental distress due to the wrongful disclosure of personal information. There is no statutory basis for awarding damages in respect of mental distress caused by a breach of confidence. There is authority

¹ See *British Steel Corporation v. Granada Television Ltd.* [1980] 3 W.L.R. 774, 823. As to the doctor/patient and therapist/client privilege in the United States. See R. Slovenko (1979) *Accountability and Abuse of Confidentiality in the Practice of Psychiatry*, *Int'l. J. Law & Psychiat*, vol. 2, pp. 431-54.

² [1991] Crim. L. Rev. 122, *The Times*, 29 August 1990, (Transcript: Marten Walsh Cherer) 23 July 1990.

³ *R. v. King* [1983] 1 WLR 411.

⁴ *W. v. Egde* (1988) *The Times*, December 14, 1988.

⁵ *Ibid.*

for awards of such damages in contract generally, but so far as non-contractual breach of confidence is concerned, there is no direct authority to support an award of damages for mental distress.¹ This places the confidant of intimate personal information in a position where he may have a right to expect that the information will be held confidential, but his remedy if a breach occurs is limited or non-existent.

20.32.10 *Disclosure of the Source of Confidential Information*

In *Special Hospitals Service Authority v. Hyde and Another*,² the managers of Broadmoor Hospital sought an injunction against the future use of confidential information and an order compelling a journalist to reveal sources. Two convicted murderers had escaped from custody and reports on the escapes were distributed to hospital staff who were informed of their confidential nature. There was a leak to a journalist who published some of the information. Broadmoor Hospital had earlier been granted an interim injunction restraining the defendant journalist and newspapers from publishing or making any further use of the documents.

The order compelling the journalist to reveal sources, however, was not granted. The court had no jurisdiction to make an order for disclosure in these circumstances. Section 10 of the Contempt of Court Act 1981 established the inviolability of a source of information with three exceptions: where disclosure is necessary in the interests of justice, in the interests of national security, or for the prevention of crime. While it was in the interests of justice to identify the source so that the management of Broadmoor could seal the leak by disciplining or dismissing the person responsible, the order was not "necessary" in the interests of justice because the hospital management had failed to conduct its own inquiry, the disclosure to the press was not of great importance, and no confidential information had actually been published. The conflict of interest in the case was between the interests of the hospital in preserving confidentiality and the interests of the public in supply of information about Broadmoor.

20.33 *Proposals for Reform of the Law of Confidence*

The Law Commission has undertaken a full review of the law of confidence and has recommended that the present action for breach of confidence should be abolished and replaced by a new statutory tort, the elements of which would be those attaching to any case of breach of a duty in tort. It recommended that an obligation of confidence should come into existence where the recipient of the information expressly gives an undertaking or where it can be inferred from the

¹ See *Bliss v. South East Thames Regional Health Authority* [1987] I.C.R. 700; *W. v. Egdell* (1988) *The Times*, December 14, 1988.

² Queen's Bench Division, 20 B.M.L.R. 75, 3 March 1994.

relationship. Damages for mental distress should be available for breach of confidence.¹

20.34 Access to Health Records

Prior to 2000, access to health care records was regulated predominantly under the Access to Health Records Act 1990 and the Data Protection Act 1984. The Access to Health Records Act applied to manually stored records whilst the Data Protection Act 1984 related to those records which were stored electronically. The position however changed in 2000. On 1st March 2000 the remaining provisions of the Data Protection Act 1998 were brought into force.² The 1998 Act gives effect to the European Directive on Personal Data³ and has repealed the Data Protection Act 1984 and most of the Access to Health Records Act 1990. The 1998 Act covers both electronic and manual health records. Manual records are those which are part of a relevant filing system. This refers to information which is structured by reference to individuals;⁴ it may be criteria relating to individuals, such that specific information which relates to individuals is accessible. Information is also covered where this is part of an "accessible record", which includes health records. These are defined in section 68(2) as:

"any record which—

(a) consists of information relating to the physical or mental health of the individual,

and

(b) has been made by or on behalf of a health professional in connection with care of that individual."

Health professionals include doctors, nurses, dentists, opticians and pharmacists.⁵ The legislation covers processing of "personal" data regarding "data subjects" by "data controllers". "Personal data" must relate to a living individual and must identify that individual.⁶

The Act sets out eight data protection principles.⁷ The first principle requires that data shall be processed fairly and lawfully and it shall only be processed as long as the criteria in Schedules 2 and 3 of the Act are complied with, *i.e.* one of the conditions in Schedule 2 and 3 must be met. In Schedule 2, information must either be disclosed with the consent of the data subject, or processing is needed to comply with a

¹ Law Com. No. 110.

² Data Protection Act 1998 (Commencement) Order 2000, S.I. 2000, No. 183 and see generally I. Lloyd *A Guide to the Data Protection Act 1998* (1998).

³ (1995) O.J. L281.

⁴ Section 1(1).

⁵ Section 69.

⁶ Section 1(1).

⁷ Schedule 1, Part II and Schedules 2–4.

legal obligation to which the data controller is subject, or is necessary for the “vital interests” of the data subject—which may include health. The Schedule also provides that processing can be undertaken for the legitimate purposes of the data controller or of third parties to whom the data is disclosed, save where it will interfere with the rights and freedoms of the data subject. The scope of this is to be explored, no doubt, as the Act is interpreted. It is to be speculated whether it may encompass such things as management purposes and audit. Schedule 3 applies to “sensitive personal data” and this includes information concerning a person’s physical and mental health or condition.¹ Schedule 3 sanctions disclosure for medical purposes by a health professional who owes a duty of confidentiality. Medical purposes here includes preventative medicine, medical research and the provision of care and of treatment. Information may also be disclosed under paragraph 3 of Schedule 3 where this is to protect the subject’s interests and they are unable to consent, or their consent cannot reasonably be expected to be obtained. Alternatively, it may be disclosed where the consent had been unreasonably withheld and disclosure is necessary to protect the vital interests of another person.

Principle 2 provides that personal data may only be obtained for specified and lawful purposes and shall be processed in a manner compatible with those purposes. Principle 3 provides that the data should be adequate, relevant and will not be excessive for the purposes for which it is being processed. Principle 4 requires that the data shall be accurate and kept up to date as necessary. Principle 5 provides that personal data shall not be kept for longer than necessary for that purpose or purposes. Principle 6 provides that the data shall be processed in accordance with the rights of the data subject. Principle 7 provides that appropriate technical/organisational measures should be taken against the unauthorised/unlawful processing of personal data and against accidental loss, destruction and damage to personal data. Principle 8 provides that personal data shall not be transferred to a country/territory outside Europe unless that state ensures adequate protection for the rights and freedoms of data subjects. These principles are subject to enforcement powers under the legislation.

Enforcement

The data protection principles are subject to enforcement by the Data Protection Commissioner. In addition, data subjects may ask for the register to be rectified,² they may claim compensation for damage and distress³ and can prevent processing of data which is likely to occasion distress or damage.⁴ In the case of a disputed decision between

¹ Section 2.

² Section 14.

³ Section 13.

⁴ Section 10.

a person on whom a notice has been served and the Data Protection Commissioner, there is provision for an appeal to the Data Protection Tribunal¹ within 28 days of the notice relating to the disputed decision being served on the applicant. At such an appeal hearing, the burden is on the Commissioner to satisfy the Tribunal that the decision should be upheld.²

Access rights

The data subject may apply for access to information under section 7 of the Act. The data controller must supply the information requested "promptly" and there is a time limit imposed of 40 days.³ In a situation in which this information is not supplied then he may be required to do so by the court.⁴ A fee may be requested, subject to a statutory maximum.⁵ In the case of health records, there are transitional provisions to 24th October 2001. The maximum fee where a permanent copy of the information is supplied is £50. However, in a situation in which the request applies simply to data which forms part of a health record and it was created in the 40 days which preceded the request and no permanent copy is going to be made, then no fee should be charged. The data controller is required to supply information as to whether an individual's personal data is being processed by or on behalf of the data controller. The subject must be given a description of the data, the purposes for which it is being processed and those recipients to whom it may be disclosed. If the subject requests it, a copy of the information shall be provided which may include an explanation of any terms which have been used.

Limitations on access rights

As with the previous legislation, the access rights are not absolute. Access to health care records may be withheld when the information may cause serious harm to the patient's physical or mental health or condition or that of another person.⁶ If the data controller is not a health professional, he must consult the health professional who has the clinical responsibility for the care of the data subject. If that health care professional is not available, he may consult a health care professional who has sufficient experience and qualifications to advise on those matters to which the information requested relates. However, this is not applicable where the data subject has already seen or knows

¹ The Data Protection Tribunal (Enforcement Appeals) Rules 2000, S.I. 2000, No. 189.

² Rule 22.

³ Section 7(8) and (10).

⁴ Section 7(2)(a).

⁵ The Data Protection (Subject Access) (Fees and Miscellaneous Provisions) Regulations 2000, S.I. 2000, No. 191.

⁶ The Data Protection (Subject Access Modification) (Health) Order 2000, S.I. 2000, No. 413.

about the information which is the subject of the request.¹ Access to information regarding the provision of treatment services and those born as a result of such treatment services and the keeping and use of gametes and embryos under the Human Fertilisation and Embryology Act 1990 are also restricted.²

Social services files

Restrictions on access also apply when access is sought to records held by social services. These restrictions are applicable where the exercise of the access rights would be likely to prejudice the carrying out of social work by causing serious harm to the physical or mental health or condition of the data subject or another person.³

Judicial proceedings

Access rights are also restricted in relation to reports of court proceedings where the information contained in the report may be withheld by the court.⁴

Information concerning identifiable third parties

Information does not have to be supplied where this relates to an identifiable third party.⁵ An identifiable individual is a person who may be identified, taking into consideration the information which is or which is likely to be in the data subject's possession.⁶ There are exceptions where that person has given their consent or if it is reasonable in these particular circumstances to disclose without consent.⁷

General exemptions

Data processed for research, statistical, or historical purposes is exempt from the access rights if it is not being processed for the purpose of supporting measures or decisions in relation to specific persons. In addition, the processing itself must not be undertaken in such a way that it causes the patient "substantial damage or distress". Finally, in the case of research, any results of that research should not be made available in a form in which the patient is identifiable.⁸ Professional regulatory bodies, such as the G.M.C. and U.K.C.C. are given some

¹ Article 6(1).

² The Data Protection (Miscellaneous Subject Access Exemptions) Order 2000, S.I. 2000, No. 419.

³ The Data Protection (Subject Access Modification) (Social Work) Order 2000, S.I. 2000, No. 415, Article 3(1).

⁴ Article 4 and Schedule 2.

⁵ Section 7(4).

⁶ Section 8.

⁷ Section 7(5).

⁸ Section 33.

protection from access provisions where this is likely to prejudice the proper discharge of their functions.¹

Incompetent patients

The situation regarding mentally incompetent adults and child patients is problematic as neither category is dealt with specifically in the legislation. This is in contrast to the Access to Health Records Act 1990 where specific provision was made for the child patient. It is unclear as to whether persons other than the data subject may make an application for access under the legislation. If they are able to, then, as this is information which concerns third parties, it would be the case that information could only be disclosed either with the third parties' consent or because it was "reasonable" to do so.² If persons such as parents or relatives are unable to make the application, then for information to be disclosed they would have to be registered as potential recipients of the information in the register.³ Information disclosed to them would then be likely to fall within the statute because it is necessary to protect the data subject's vital interests⁴ and the information would be disclosed for medical purposes.⁵

Residual access rights under the Access to Health Records Act 1990

While the majority of the provisions in the 1990 Act have been superseded by the 1998 Act, access to health records of a deceased person are not covered by the 1998 Act. Personal representatives⁶ or persons claiming in relation to the deceased's estate⁷ must make an application under the 1990 Act.

The transitional arrangements

Where a data user was registered under the 1984 Act, this will be deemed as continuing under the 1998 Act until either the date on which his entry would have been due to be removed under the 1984 Act or 24th October 2001.⁸ Claims by the data subject for damages/distress under the 1984 Act are still sustainable after the 1998 Act came into force where the claim relates to the period in which the 1984 Act was still in force. Applications for rectification and erasure will still be referable to the 1984 legislation. In relation to enforcement notices, where an appeal is brought in relation to a notice issued under the 1984 Act, the appeal will be conducted under the old legislation.⁹

¹ Sections 31(2)(a)(iii), 31(4)(a)(iii), 31(4)(b).

² Section 7(4).

³ Sections 17 and 18. See also section 16(1)(e).

⁴ Schedule 2, para. 4.

⁵ Schedule 3, para. 8.

⁶ Section 3(1)(f).

⁷ Section 5(4).

⁸ Schedule 14, para. 2.

⁹ Schedule 14, paras. 7 and 8.

In *R v. Mid Glamorgan Family Health Services Authority and South Glamorgan Health Authority ex parte Martin*¹ Popplewell J held that there was no right at common law to access to records which predated the 1990 Act, and that Article 8 of the European Convention, recognising the right of respect for family and private life, was of no assistance to the applicant, because the common law was clear, and needed “no assistance from Europe.”² The Court of Appeal dismissed Mr Martin’s appeal. Nourse LJ, delivering the leading judgment, held that a doctor, and 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 so to do, for example if the disclosure would be detrimental to his health. A health authority does not have an absolute right to deal with medical records in any way it chooses. It has to act at all times in the best interests of the patient. “These interests would usually require that a patient’s medical records should not be disclosed to third parties; conversely that they should 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 litigation in which he is involved.”³

20.35 Access to Social Services Records

The Department of Health has issued guidance on the safeguarding of personal information which local authorities hold in their records for social services purposes and which enables individuals to be identified.⁴ It covers the disclosure of such information to other organisations, but does not deal with access by the individual himself to the information.

The Access to Personal Files Act 1987 complements the rights of access of individuals under section 21 of the Data Protection Act 1984 to electronically stored personal data about them. It plays the same role in relation to local authority records as does the Access to Health Records Act 1990 in relation to manually stored health records. The 1987 Act is primarily enabling, and the detailed scheme of regulating the keeping of and granting of access to information is specified in regulations made under section 3.⁵ Local social services authorities are obliged to inform an individual whether they hold any information about him and to give him access to any personal information of which he is the subject.⁶ The individual must apply in writing, supplying

¹ (1993) 16 B.M.L.R. 81.

² *Ibid.*, p. 97.

³ *R v. Mid Glamorgan Family Health Services Authority ex parte Martin* [1995] 1 W.L.R. 110 at 117, [1995] 1 All E.R. 356, at 363.

⁴ Department of Health Circular No. LAC(88)17 Personal Social Services: Confidentiality of Personal Information, extended beyond 1 January 1994 by Circular No. LASSL(92)7.

⁵ The Access to Personal Files (Social Services Regulations 1989, S.I. 1989 No. 2067, as amended by S.I. 1991 No. 1587.

⁶ *Ibid.*, r. 2.

sufficient information to enable the authority to identify him and locate the information, and must pay a fee.¹ If the information sought includes information relating to another individual, the authority must inform that person and ask whether he consents to the information relating to him being disclosed. If the other individual refuses, the information may not be disclosed, unless he is an employee of the authority or has performed for reward a function a similar to a social services function.

Exemptions apply in relation to information as to the physical or mental health of an individual which originated from, or was supplied by or on behalf of a health professional. In such a case the local authority must inform the relevant health authority or NHS Trust where the information originated, or in other cases the appropriate health professional from whom it was obtained. The information need not be disclosed if, within 40 days, the health authority, Trust or appropriate professional informs the local authority that disclosure would be likely (a) to cause serious harm to the physical or mental health of the individual who is the subject of the information or any other person; or (b) would be likely to disclose the identity of another individual (other than a health care professional who has cared for the subject) who has not consented to the disclosure of the information.² As regards information which has not originated from a health professional, information need not be disclosed if the carrying out of the social services functions of the authority would be prejudiced due to the fact that serious harm to the physical or mental health or emotional condition of the individual who is the subject of the information or any other person would be likely to be caused.³ These provisions only exempt from disclosure so much of the information as needs to be withheld to avoid the deleterious effects contemplated. Individuals may apply for the rectification of any information which they consider to be inaccurate, and the authority must correct it if they are satisfied that it is inaccurate, or note the individual's view at the appropriate part of the records.⁴ A person who is aggrieved by any decision of the authority on access or rectification may appeal within 28 days of notification of the decision to a committee of three members of the authority, no more than one of whom may be a member of the social services committee.⁵

¹ *Ibid.*, rr. 3 and 4.

² *Ibid.*, r. 8.

³ *Ibid.*, r. 9.

⁴ *Ibid.*, r. 10.

⁵ *Ibid.*, r. 11.