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THE IMPACT OF PATIENTS' AUTONOMY IN MEDICAL PRACTICE IN THE UNITED KINGDOM: INFRINGEMENTS AND REMEDIES

Key Words: *autonomy; community interests; infringement; justification for infringement, patient's best interest; remedies; unjustified infringement*

1. Introduction

Since inception by about the middle of the 20th century, autonomy has not only shown medical paternalism the door, it has been empowered to the extend that the autonomous patient now participates in the designed, commissioning and monitoring of his healthcare service; and when aggrieved with its provision, to challenge the cause of aggrieve. Today's patient has gone beyond expectation to demand his healthcare services; and when this does not happen, he deems to have been infringed of his autonomy.

The methodology of the work has already been described in the first report. In that report the respective responsibilities of the stakeholders were defined; each being pivotal to facilitating the patient to realise and maximise his autonomy. Whereas the autonomy of the patient is increasingly amassing ground, that of the doctor is yet undefined. To a great extend, while there are machineries on ground for all stakeholders to work together unabated, inevitably, there are times conflicts which may involve apparent or real infringement of the patient's personal integrity arise. This second report deals with the subject of infringement and the remedies. The paper looks at when a patient's autonomy may be infringed, and the possible remedies.

2. Justification for infringement

2.1. For patient's best interests.

In some instances infringement may be justified for patients that lack capacity and are, thus, incompetent to rationally discharge their responsibility with regards to consent, and where the treatment is a therapeutic necessity for their benefit or for the safety of others. Such treatment could, then, be lawfully imposed on them and this may be done at times with some restraint or detention. This can, however, be done in the patient's best interests as, for example, in *Norfolk NHS Trust v W*[1] and *HL v United* Kingdom[2]. In the event of the patient being incapacitated through, say accident, the doctor is authorised by section 5 of the Mental Capacity Act 2005 to act in the best interest of the patient[3].

At times a doctor may institute non consensual treatment on even the capax on ground of what he considers from his professional judgment to be in the best interest of the patient, but could, then, face legal action by the same patient for invading his/her privacy; as in *St George's Healthcare NHS Trust v S (Guidelines), R. v Collins ex p. S*

(No. 1)[4],where a 36 weeks pregnant patient with pre-eclampsia refused to consent to urgent medical treatment, having been advised on the life threatening nature of her condition and the need for urgent medical intervention. Following her refusal to consent to treatment, her social worker obtained the consent of two doctors for her compulsory admission under the Mental Health Act 1983 s.2. She was transferred to another hospital which made an *ex parte* application to a judge, who granted a declaratory order dispensing of her consent and she was admitted and treated, including a Caesarean section.

The patient appealed against her detention and applied for judicial review. Her application was granted, on the grounds of her autonomy, that, «…irrespective of the risks to her life, an adult of sound mind had the right to refuse medical treatment. Where that adult was a pregnant woman and there was conflict between the interests of mother and foetus in terms of the proposed treatment, the unborn child's need for medical help did not override the mother's right to refuse invasive treatment, however repugnant her decision might seem in moral terms». The ruling in this case seemed to have extended deference to autonomy to the point where it results in the death of a foetus.

However, the ruling in *R (on the application of PS) v G (Responsible Medical Officer)* was different[5]. In this case the patient, P, was detained under the Mental Health Act 1983 s.37 upon his conviction, on a plea of diminished responsibility, for the manslaughter of his mother and son, and was vulnerable to recurrence of depression. G, the responsible medical officer considered it justifiable to give the proposed treatment, and his decision was affirmed by the second appointed doctor, W, in accordance to s 58(3)(b) of the 1983 Act. P had the capacity to decide on his treatment, and he did not want it, arguing that his personal choice to refuse treatment be respected.

In the presence of capacity, the issue of personal autonomy is central to the law, the law allowing such patients to make decisions to their treatment that is unreasonable. He argued that to provide treatment against his wishes would infringe his human rights under the Human Right Act 1998 Sch. 1 Art. 3 and 8. His application was refused by the court on ground that administration of the treatment was not an infringement of P's rights under Art 3 and Art. 8., in view of the possible benefits to P and the limited adverse consequences of the treatment. The court saw the decision G took and certified by W as being in accordance with responsible medical opinion, and that the treatment was necessary for the protection of P's health and the safety of others.

2.2. For public interest

While individual patients' best interests remain central in the issue of autonomy, the health interests of his community for example may be so strong that they override his, thus necessitating compulsory denial of his bodily integrity, rights and freedoms6. This is not to say public interest always triumph over individuals'; where that has to be, it must be justified, minimal and necessary. Consequently if lawful detention were required it must be authorised by statutory powers to avoid action against trespassing on the patient's autonomy7. For example, the Public Health Act (1984) aims to protect the public against public health hazards such as communicable diseases and new epidemics8. However, the patient's confidentiality at the face of his autonomy is crucial. This is already defined in the Data Protection Act 1988. While the Data Protection Act 1988 gives recognition to the need to respect the individual's autonomy for confidentiality, it makes room for some breach of same. But public interests have to be critically weighed within the realms of the patient's autonomy for confidentiality. In the case of infectious diseases for example, the fact that on one hand it is compulsory for a practitioner to report a communicable disease, on the other, he is essentially asked to breach his patient's autonomy for confidentiality9.

A different perspective on the care for others lies in the patient's responsibility in safeguarding others from disease, in particular, infectious disease. In *R v Dica (Mohammed)*[10]

the applicant appealed against his conviction for inflicting bodily harm. He had been diagnosed HIV positive and infected the complainant after having unprotected consensual sexual intercourse with her. The appeal was dismissed, the ruling being on account of public importance namely «…a defendant who knows or believes he is infected with a serious sexually transmitted infection and recklessly transmits it to another through consensual activity…commits an offence of inflicting grievous bodily harm». It is important patients know they cannot have it both ways – to choose to exercise their autonomy by embarking on reckless living but not to want to carry the responsibility of their harmful conduct on others. The same was the ruling in an earlier case, *R v Barnes (Mark)*[11].

3. Unjustified infringement

While the previous section dealt with what reasonably is justified infringement, there are instances when infringement on patients' autonomy takes unjustifiable tune. For example, in *B v NHS Hospital Trust*[12] the patient, B, with severe physical disability, sought declaration that she had the necessary mental capacity to give or refuse consent to medical treatment. B became tetraplegic following a ruptured blood vessel in her neck and needed artificial respiration to sustain her life. But the Trust refused her request to turn off the artificial ventilator. B's application was granted on ground that «…a mentally competent patient with serious physical disability had the same right to personal autonomy and to make decisions as any other person with mental capacity». The court went on to say «…In assessing the competence of a patient, doctors should not allow the question of mental capacity to be confused with the consequences of the patient's decision, however serious. In the instant case, B had possessed the requisite mental capacity to make decisions regarding her treatment and thus the administration of artificial respiration by the trust against her wishes had amounted to an unlawful trespass».

At times autonomy could be deemed infringed even in instances of care by the doctor out of professional good intention. In *Chester v Afshar*[13], where the breach of duty of care was a failure to provide the patient with information that would have warned her of a 1–2% risk of partial paralysis associated with her surgery. In spite of performing the surgery to a skilful standard the patient suffered significant nerve damage that left her with partial paralysis. The patient's argument was that had she been properly warned of the inherent risk associated with the surgery, she would not have consented to having it within three days of her appointment, but sought further advice on other alternatives. The surgeon's appeal was dismissed by a majority of the House of Lords on the grounds that the test for causation had been satisfied – although, and importantly, in so doing they modified the law in favour of a failure to acknowledge the woman's autonomy. The ruling in this case stresses the need for the doctor to ensure the patient is given all the relevant information required to make an informed decision on the treatment on the offer.

A very similar and apposite case to *Chester v Afshar* is *Rees v Darlington*[14] In this case a severely visually impaired mother, who did not want to have children as she considered she would be unable to meet their parental responsibilities, gave birth to a healthy son following a failed bilateral tubal ligation, consequently sued the Trust for damages. The Trust appealed against an earlier ruling allowing the mother to recover extra costs of raising a healthy child attributable to her disability, arguing that the decision was inconsistent with *McFarlane v Tayside Health Board*[15]. In a counter appeal to uphold the decision, the mother asked the court to reconsider *McFarlane,* claiming the whole cost of raising the child. Allowing the Trust's appeal, the House of Lords (3 out of 7 dissenting) held that the policy considerations in *McFarlane* which prevented recovery of the cost of a healthy child's upbringing still held. The House, however, made a conventional award as this was just, fair and reasonable; to reflect the mother's loss of opportunity to limit her family and

to live the way she had planned – i.e. her autonomy was infringed. The award in this case has been rightly described by JK Mason in his analysis of the case, as recompensing her in a way that she was otherwise not entitled[16].

The protection of the individual's privacy in relation to medical research is emphasised in statute such as The Human Tissue Act 1961 in the UK102[17], The Data Protection Act 1998[18] and the Access to Health Records Act 199018[19], conventions such as The Additional Protocol to The Convention on Human Rights and Biomedicine, Concerning Biomedical Research[20] and declarations including The Declaration of Helsinki[21]. Many of these have been stimulated by blatant infringements in the past. This stresses the need to respect the human rights of the patient by ensuring that informed consent is obtained before his participation on any treatment or research. But quite often, in particular on the issue of informed consent, such rights are breached and, consequently, participants are aggrieved.

4. The remedies for infringement

At the face of current renewal of interest and awareness of the need for collective and individual responsibility on healthcare delivery by government, the public and healthcare professionals thus allowing government, through their agencies for healthcare provision, to intervene in private lives and lifestyles for public benefits. However, this is happening in an era of human rights recognition that gives new ways of challenging government decision making and seeking remedies for breaches of rights or failure to protect them[22]. The effect is increasing erosion of immunities against litigation of private and public bodies as the courts are becoming more attuned to recognising their accountability thus making them to be increasingly found legally responsible for the ways in which they exercise their powers.

Regardless of the reason for infringing autonomy there is duty to give reason for such infringement. To this Lord Justice Sedley in *John W v Dr Graham Feggetter and Mental Health Act Commission* [23] said «…it can be said that the impact of the decision (to infringe – give treatment without consent) is so invasive of physical integrity and moral dignity that it calls without more for disclosure of the reasons for it in a form and at a time which allows the individual to understand and respond to them…No public lawyer supposes that the last word has yet been said on the duty to give reasons…I agree that …the patient is entitled, not as a matter of grace or of practice but as a matter of right, to know in useful form and at a relevant time what the SOAD.s reasons are for his opinion on the RMO's proposal to override his will». Applying *R. (on the application of Wilkinson) v Broadmoor Hospital*[24] *R. v Civil Service Appeal Board Ex p. Cunningham*[25] and *R. v Secretary of State for the Home Department Ex p. Doody*[26], the ruling in favour of the patient was on not violating his autonomy but the failure of the SOAD to provide him with adequate written reasons for the violation.

This sounds a strong word of caution to healthcare providers for the need for extraordinary caution in the application of legal procedures at the advent of violation of autonomy than otherwise. Nothing can equate reading between the lines of the guidelines of such set down procedures. The significance of such caution was furthermore highlighted in *R. (on the application of B) v S (Responsible Medical Officer, Broadmoor Hospital)*[27], thus «… it was undesirable for medical practitioners to attend court as witnesses to give evidence where treatment under s.58 was in issue in judicial review proceedings… Where the issue concerned the treatment itself, careful consideration should be given to the appropriate procedure to minimise the need for protracted and expensive legal proceedings requiring oral evidence from medical witnesses where there was no prima facie case that anything untoward had happened».

However, in *Regina v Department of Health*[28], the applicants who collected information from general practitioners and pharmacists about drugs prescribed to patients, anonymous and used such information for

marketing purposes, the question was whether disclosure of such information breached duty of confidence owed to patients? The Department of Health had issued a policy guideline advising that the anonymities of information would not remove the duty of confidence owed to patients, thus legal risk. The applicants brought judicial review proceedings against the Department of Health seeking a declaration that the policy guidance was wrong and that disclosure of such information would not be breach of confidence. The deciding judge dismissed the application, holding that in the absence of consent from patients, disclosure of information abstracted from their prescription forms was breach of confidentiality even if the information was anonymous. However, the applicants appealed and their appeal was held, that a patient had no proprietarily claim to the prescription form or to the information it contained and no right to control the way the information was used provided only that his privacy was not put at risk; that where the patient's identity was protected it would not be a breach of confidence for the information to be disclosed to a third party.

5. Conclusion

From the foregoing in this report, infringement, in whatever form and for whatever reason, has come to stay in the medical profession as long as autonomy remains, as it sounds a vanguard for the latter. It takes the profession itself, the patients and the law to have a positive approach to it if it must have a growing positive impact on healthcare delivery. For this, fine-tuning autonomy is imperative. This is the subject of the last instalment of the report from the present research.

1. *Norfolk NHS Trust v W* [1996] 2 FLR 613
2. *HL v United Kingdom* [2004] 40 EHRR 761
3. 35. Mental Capacity Act (2005) s.5
4. *St George's Healthcare NHS Trust v S, R. v Collins ex p. S (No. 1* [1998] 3 W.L.R, 936)
5. *R (on the application of PS) v G (Responsible Medical Officer* [2003] EWHC 2335
6. Mason & Laurie, Smith's Law and Medical Ethics (2006), at 2.2, 7th ed Oxford, Oxford University Press.
7. Martin R Public health and the scope of potential liability in tort. Professional Negligence (2005) 21, 39–68
8. Public Health Act (1984)
9. Mason & Laurie, Smith's Law and Medical Ethics (2006), at 2.10, 7th ed Oxford, Oxford University Press.
10. *R v Dica (Mohammed)* [2005] 1 WLR 2303; [2005]UKHL 44; [2005] 4 All ER
11. *R v Barne s(Mark)* [2004] EWCA Crim 3246; [2005] 1 WLR 910; [2005] 2 All ER
12. *B v NHS Hospital Trust* [2002] 2 All E.R. 449
13. *Chester v Afsar* [2004] UKHL 41
14. *Rees v Darlington Memorial Hospital NHS Trust* [2003] UKHL 52; [2003] All ER 987
15. *McFarlane v Tayside Health Board* [2000] 2 A.C. 59; [1999] 3 WLR 1301; [1999] 4 All ER
16. JK Mason The troubled pregnancy legal wrongs and rights in reproduction (2000) pp 179, Cambridge, Cambridge University Press.
17. Human Tissue Act 1961 (repelled)
18. Data Protection Act 1998
19. Access to Health Records Act 1990
20. The Additional Protocol to The Convention on Human Rights and Biomedicine, Concerning Biomedical Research (Strasbourg, 2005)
21. The Declaration of Helsinki (as revised at Edinburgh 2000)
22. Martin R Public health and the scope of potential litigation in tort. *Professional Negligence* (2005), 21, 39–68)
23. *John W v Dr Graham Feggetter and Mental Health Act Commission* [2002] EWCA Civ. 554)
24. *R. (on the application of Wilkinson) v Broadmoor Hospital* [2001] EWCA Civ 1545)
25. *R. v Civil Service Appeal Board Ex p. Cunningham* [1991] 4 A11 E.R.)
26. *R. v Secretary of State for the Home Department Ex p. Doody* [1994] 1 A.C.)
27. *R. (on the application of B) v S (Responsible Medical Officer, Broadmoor Hospital)* [2006] EWCA Civ 28)
28. *Regina v Department of Health* [2001] Q.B. 424)

РЕЗЮМЕ

Це друга частина дослідження, присвяченого впливу автономії пацієнта на медичну практику у Сполученому Королівстві, яка стосується питань порушення принципу автономії. Розглядаються різні аспекти порушення цього принципу. Також йдеться про юридичні засоби захисту.

РЕЗЮМЕ

Это вторая часть исследования, посвященного влиянию принципа автономия пациента на медицинскую практику в Соединенном Королевстве, которая затрагивает вопросы нарушения принципа автономии. Рассматриваются различные аспекты нарушения этого принципа. Также рассматриваются юридические средства защиты.

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