

Medical Law

Artificial Nutrition and Hydration (ANH) (Hypothetical Scenario)

Alain is suffering from an incurable neurological disease and has taken steps to construct a signed advance directive to prevent possible denial of artificial nutrition and hydration (ANH) during the palliative stage of his illness. The appointed doctor has already expressed a refusal to comply with his wishes should such actions be deemed futile, so his estranged wife has agreed to support his wishes as much as is practicable. As part of this she is seeking legal advice to support her arguments against the doctor and the hospital.

When discussing the nature of advance directives it must be stressed that by definition they confer a negative proscription upon the recipient, therefore the correct application is one that requires the cessation of medical care or specific treatment.¹ However what Alain is asking for is the exact opposite, and in accordance with para.56 of the Law Commission report on mental capacity² it has been stressed that no advance-signed document from a patient can override the reasonable and responsible clinical judgment of a medical doctor, which means at first glance there is little either Sophia or Alain can do in this regard other than rely upon the decision in *R (on the application of Burke) v General Medical Council* whereby Lord Philips commented:

No such difficulty arises, however, in the situation that has caused Mr. Burke concern, that of the competent patient who, regardless of the pain, suffering or indignity of his condition, makes it plain that he wishes to be kept alive. No authority lends the slightest countenance to the suggestion that the duty on the doctors to take reasonable steps to keep the patient alive in such circumstances may not persist.³

A position that (while in relation to a minor) was established in the earlier judgment of Lord Donaldson MR in *Re R (A Minor) (Wardship: Medical Treatment)*⁴ who expressed 'no doctor can be required to treat a child, whether by the court in the exercise of its wardship jurisdiction, by the parents, by the child or by anyone else. The decisions whether to treat is dependent upon an exercise of his own professional judgement.'

However while not legally binding, art.13 of the European Social Charter 1961 allows that:

With a view to ensuring the effective exercise of the right to social and medical assistance, the parties undertake: (1) to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources...be granted adequate assistance, and, in case of sickness, the care necessitated by his condition.⁵

Therefore while denial of medical treatment may be argued as falling beyond the scope of this provision, it would not be unreasonable to expect that basic needs care such as nutrition and hydration fall to live within it. This is further extended through the application of HRA 1998, notably art.2 (everyone's right to life shall be protected by law) and is equally supported in art.3 (no one shall be subjected to torture or to inhuman or degrading treatment or punishment); however there appears to be a general consensus that legal enforcement of a right to receive treatment during end-of-life illness has yet to receive positive interpretation from the courts, which suggests that until a precedent is established the chances of successful appeal against such medically based decisions are small.

¹ Mental Capacity Act 2005, sub-s 24

² Law Commission, 'Mental Incapacity Item 9 of the Fourth Programme of Law Reform: Mentally Incapacitated Adults' (Law Com 231, 1995) 67

³ [2004] EWHC 1879 [34].

⁴ [1991] 4 All ER 177 [26]; *Re J (A Minor) (Consent to Medical Treatment)* [1992] 4 All ER 614.

⁵ European Social Charter 1961, art 13

Sterilisation (Hypothetical Scenario)

Sophia's 22 year-old daughter Megan suffers from severe learning disabilities and possesses the mental capacity of a four to five year-old child. Since occupying a residential home she has struck up a friendship with another resident, sparking fears that their relationship could become sexual hence Sophia's wish to have her sterilised, a decision that also needs legal consideration.

S.2(1) of the MCA 2005 explains how a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain⁶ while c.4 s.4.12 of the MCA 2005 Code of Practice⁷ further clarifies that significant learning disabilities constitute an impairment or disturbance of the functioning of the brain.

This would indicate that Megan is not able to make informed decisions regarding her vulnerability to an unwanted pregnancy and that perhaps Sophia may be able to act on her behalf. However in *A Local Authority v Mrs A and Mr A*⁸ it was decided that while suffering from low level intellectual capacity, rather than denying the respondent the right to decide upon acceptance of contraception the court asked instead that the local authority used their powers to persuade her into consent. This approach may be worth pursuing with regard to Megan, as distress during times of menstruation does not necessarily indicate a lack of cognisance nor an inability to weigh up the effects of sterilisation when those facts are comprehensively presented.

More importantly, forced sterilisation is seen or at least considered as a last resort, primarily because the act when performed on those deemed to lack capacity stands in breach of art.3 and art.8 of ECHR therefore alternative methods must be first exhausted before the court would grant permission, as per *A Local Authority v K*⁹ where sterilisation of a 21 year-old down syndrome daughter through local authority declaration needed greater consideration of the invasive nature involved as well as appreciation for the long-term effects, particularly when other options were at the parents disposal. This reluctance to grant overriding determination of a right to motherhood was echoed by Heilbron J who commented:

...the type of operation proposed is one which involves the *deprivation of a basic human right*, namely the right of a woman to reproduce, and therefore it would, if performed on a woman for non-therapeutic reasons and without her consent, be a violation of such right...¹⁰

Therefore although Sophia would be able to apply for a declaration for sterilisation, the court of protection operating under Practice Direction 9E¹¹ of the Court of Protection Rules 2007 will undoubtedly have final say and when doing so be required to not only reflect upon past cases of a similar nature¹², but also avoid accusations of eugenic sympathies as first expressed by Wendell Homes J in *Buck v Bell*¹³ who said 'it is better for all the world if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind' before agreeing (where agreement can be found) that Megan would be unable to learn how to nurture and sustain the life of an as yet non-conceived child.

⁶ Mental Capacity Act 2005, s 2(1)

⁷ Department for Constitutional Affairs, 'Mental Capacity Act 2005: Code of Practice' <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf> accessed 18 March 2016

⁸ [2010] EWHC 1549 (Fam).

⁹ [2013] EWHC 242 (cop).

¹⁰ Re D [1976] 1 All ER 326 (emphasis added).

¹¹ Courts and Tribunals Judiciary, 'Practice Direction 9E: Applications Relating to Serious Medical Treatment' <<https://www.judiciary.gov.uk/wp-content/uploads/2015/06/copd-pd-9e-serious-medical-treatment.pdf>> accessed 22 March 2016

¹² Re B [1987] 2 All ER 206; *Re W (Mental Patient)* [1993] 1 FLR 381; *Re X (Adult Patient: Sterilisation)* [1998] 2 FLR 1124.

¹³ 274 US 200 (1927)

In Vitro Fertilisation (Hypothetical Scenario)

Prior to her treatment for ovarian cancer, Sophia and Luca underwent fertility treatment (in accordance with current legislation) whereupon the created embryos were subject to cryopreservation. Since that time Luca has expressed his unwillingness to complete the process therefore Sophia is seeking advice regards her continuation of the treatment alone.

To date there is little case law found in relation to a woman's desire to undergo assisted reproduction technology (ART) upon the breakdown of an existing relationship with the male participant. The leading domestic case is *Evans v Amicus Healthcare Ltd*¹⁴ which centred around a couple in a long-term relationship who when learning that the appellant had been diagnosed with ovarian cancer, took the decision to undergo *in vitro* fertilisation (IVF) despite express concerns on the part of the appellant surrounding the strength of their relationship.

With assurances from the respondent that things would be fine, the embryos were created and subsequently frozen for future use by both parties. It was during this period that the relationship ended and the respondent withdrew his consent, a right supported by the HFE Act 2008:

The terms of any consent under this Schedule may from time to time be varied, and the consent may be withdrawn, by notice given by the person who gave the consent to the person keeping the gametes or embryo to which the consent is relevant.¹⁵

When the judge granted favour in the destroying of the frozen embryos, the appellant escalated her argument to the Grand Chamber of the European Court of Human Rights, citing violation of art.8 when denied a right to continue fertilisation alone.¹⁶ When evaluating the needs of both parties the court found that serious consideration of the sensitive and moral issues meant that the welfare of any child born from ART must remain paramount to the discussion, which on this occasion pointed toward a father that had no willingness to become so. Furthermore s.13 (5) of the HFE Act 1990 provides that 'a woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child of a father)...'¹⁷

While extrinsic to domestic rule *Davis v Davis*¹⁸ demonstrated a similar stance when a married couple placed unused embryos on stasis with the intention to use them for themselves, but following their divorce the father immediately requested they be destroyed while the mother had asked that they be donated to families suffering from infertility. The supreme court held that the desire to have them disposed of outweighed any charitable notion, particularly as the father would be living in the knowledge that one of his offspring was without a genetic father.

Sophia's situation with Luca remains slightly different inasmuch as the couple have not officially separated, therefore should they be able to reach a mutual understanding and heal the existing rift the HFE Act 2008 also provides that where consent is withdrawn by one party then further lawful storage for a period of up to 12 months is granted in order to facilitate reconciliation between said parties.¹⁹ The purpose of this was to prevent premature embryonic destruction and once in effect, termination of the embryos cannot be carried out without dual consent. So with all the facts considered it might still be possible to continue with the original IVF programme provided Sophia and Luca are again in full agreement.

¹⁴ [2004] 3 All ER 1025.

¹⁵ Human Fertilisation and Embryology Act 2008, sch 3, para 4(1)

¹⁶ *Evans v UK* (Application no. 6339/05) [2006] ECHR 200.

¹⁷ Human Fertilisation and Embryology Act 1990, s 13(5)

¹⁸ 842 SW 2d 588 (1992).

¹⁹ Human Fertilisation and Embryology Act 2008, sch 3(4A)

Patient Confidentiality (Hypothetical Scenario)

Francesca practices as a junior doctor at a nearby hospital and in the course of her duties within the A&E department, received local politician Philip Roper who was suffering a (serious) self-inflicted stab wound to the stomach. While providing medical care, Philip requested that his condition was to remain confidential and that the police authorities were not be informed. The advice sought by Francesca is what her obligations were when treating him?

The fundamental medical principle ascribed doctors in the United Kingdom which is known as the Hippocratic Oath reads ‘all that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and never reveal.’²⁰ Although created over 2000 years ago it is the bedrock of conduct for all practicing doctors, and despite calls for reformation²¹ it remains unchanged; so serving instead as judicial ethos the words of Lord Phillips MR provide that:

It is well settled that there is an abiding obligation of confidentiality as between doctor and patient, and in my view when a patient enters a hospital for treatment, whether he be a model citizen or murderer, he is entitled to be confident that details about his condition and treatment remain between himself and those who treat him.²²

While Baroness Hale also expressed in *Campbell v Mirror Group Newspapers Ltd* ‘It has always been accepted that information about a person’s health and treatment for ill-health is both private and confidential this stems not only from the confidentiality of the doctor-patient relationship but from the nature of the information itself’.²³ However the serious nature of the injuries sustained by Philip place Francesca in a precarious position and one of conflict.

When observing the General Medical Council (GMC) guidelines surrounding gunshot and knife wounds²⁴ para.7 explains that the police should not usually be informed if a knife or blade injury is accidental or a result of self-harm, yet para.8 also states that quick reporting to the police helps prevent further harm (particularly where the doctor has responsibility for the patient). Para. 9 then goes on to say that personal information such as the patient’s name and address do not need to be disclosed but the police will respond anyway, which in Francesca’s circumstances would be the most viable course of action.

To then go ahead with disclosure despite Philip’s request for confidentiality, Francesca would be expected to apply principles one (justify the purpose(s)) and three (use the minimum necessary personal confidential data) of the revised Caldicott Principles²⁵ (while not overlooking principle six: comply with the law) in order to avoid a loss of anonymity. This approach is also supported by principle one of the GMC guidelines surrounding protection and provision of information.²⁶

²⁰ Elizabeth Wicks, *Human Rights and Healthcare* (Hart 2008) 124

²¹ British Medical Association, ‘BMA Updates Hippocratic Oath’ (27 March 1997) <<http://web.bma.org.uk/pressrel.nsf/wall/776B5BE6D9D1D2D0802568F50054301D?Open>> accessed 7 April 2016

²² *Ashworth Security Hospital v MGN Ltd* [2000] 1 WLR 515 [527].

²³ [2004] 2 All ER 995 [145].

²⁴ General Medical Council, ‘Confidentiality: reporting gunshot and knife wounds’ <http://www.gmc-uk.org/Confidentiality___reporting_gunshot.pdf_58821618.pdf> accessed 7 April 2016

²⁵ Department of Health, ‘Information: to share or not to share’ <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251750/9731-2901141-TSO-Caldicott-Government_Response_ACCESSIBLE.PDF> accessed 7 April 2016

²⁶ General Medical Council, ‘Confidentiality: Protecting and Providing Information’ <http://www.gmc-uk.org/10a_annex_a.pdf_25398020.pdf> accessed 7 April 2016

Public Disclosure (Hypothetical Scenario)

During the course of Philip's treatment he was recognised by a senior staff nurse and photocopies of his personal medical records were then presented to the media on the grounds of public interest. Philip has asked what measures are available to prevent any subsequent publication of this data and what type of remedy might be provided, along with any defences he might expect when challenging it?

While the leading case regards public interest disclosure is *W v Egdell*²⁷ the facts presented are not comparable and are therefore in some degree of conflict. In *Egdell* a psychiatrist disclosed confidential inmate information with the home office and hospital director in a manner that breached his professional relationship with his patient. The breach was defended upon grounds that his release would have undoubtedly caused serious harm to both the inmate and those he may have come into contact with; whereas with Philip we have only circumspice to support the idea that he was stabbed while frequenting an area known for prostitution; therefore disclosure to the media on grounds of public interest seems somewhat implausible.

Despite the complexity surrounding the doctor-patient relationship there is no existing statute nor common law applicable to breaches of medical confidentiality, therefore any claims for damages become contractual, tortious, equitable and even criminal (while providing limited awards); however disclosure on the grounds of public interest can only be determined by the courts, hence any choice to disclose remains purely subjective and with an attached burden of proof.²⁸

With regard to prevention of publication, exercise of the 'balance of convenience test' as was first used in *Mitchell v Henry*²⁹ means that an interlocutory injunction could be awarded should the courts find that irreparable harm has been caused to the party claiming the breach; this remedy would in itself help prevent any public release of Philip's medical records and recent injury.

A breach of contract claim also bears consideration when a breach of confidentiality forms part of the disclosers employment agreement³⁰ (which on this occasion it does³¹) although any available remedy would be decided by the employer and *not* the patient unless pursued under the Contracts (Rights of Third Parties) Act 1999.

The tortious misuse of private information has been found to hold up when used in conjunction with art.8 of the ECHR (right to respect for private and family life) as was seen in *Campbell v MGN Ltd*³² (although the *exact* extent of the tort of privacy is still developing), while with specific regard to the activities prior to Philip's injury *Mosely v News Group Newspapers*³³ demonstrated the courts willingness to protect information relating to the sexual activities of a public figure.

We move then to the equitable obligation to respect confidential information which is subject to four criteria:

- (1) The information disclosed must be of private or personal and intimate nature.
- (2) The information must be imparted in circumstances imposing an obligation of confidence.
- (3) There must be evidence of suffering should the information be disclosed.
- (4) That in order for a breach to exist the information must have been viewed by an unauthorised person.

²⁷ [1990] Ch 359.

²⁸ General Medical Council, 'Confidentiality: Protecting and Providing Information' para 25 <http://www.gmc-uk.org/10a_annex_a.pdf_25398020.pdf> accessed 6 May 2016

²⁹ [1880] 15 Ch.D. see also *American Cyanamid v Ethicon Ltd* [1975] AC 396.

³⁰ *X v Y* [1988] 2 All ER 649.

³¹ Jonathan Herring, *Medical Law and Ethics* (5th edn, OUP 2014) 232 ch 5 para 4

³² [2004] UKHL 22. see also *Douglas v Hello* [2007] UKHL 21.

³³ [2008] EWHC 687 (QB).

This approach would appear to lend the greatest weight to Philip's claim as it embraces all of the requirements set by equity; although despite the long standing principle that information is not property that is capable of being stolen³⁴, the senior staff nurse photocopied Philip's medical records prior to giving them to the newspaper, which constitutes theft of hospital property regardless of the fact that it contained such important information.

In consideration of any defence that may be offered the facts of *H (A Healthcare Worker) v Associated Newspapers Ltd* and *N (A Health Authority)* may help the senior staff nurses decision to commit a breach of confidentiality, particularly when taken with art.10 of ECHR (freedom of expression) and the words of Lord Phillips MR:

We would view with concern any attempt to invoke the power of the Court to grant an injunction restraining freedom of expression merely on the ground that release of the information would give rise to administrative problems and a drain on resources. Such consequences are the price which has to be paid, from time to time, for freedom of expression in a democratic society.³⁵

Furthermore while health records are considered 'sensitive personal data'³⁶ and are supported by EU law,³⁷ elements of the act translate that lawful processing of patients records exists when '...it is necessary for the purposes of 'legitimate interests' pursued by the data controller or the third party to whom the data is to be disclosed...'³⁸

In the case of *H* the doctor's identity was eventually protected but not his specialism, which allowed the public to receive adequate information without any risk of total exposure; therefore this defence may be sufficient enough for the court to permit a publication that while serving the interests of the public allows for individual privacy to remain intact (albeit not entirely free of controversy).

³⁴ *Oxford v Moss* [1978] 68 Cr App R 183.

³⁵ [2002] Lloyd's Rep Med 210 (CA) [41].

³⁶ Data Protection Act 1998, s 2(e)

³⁷ Council Directive 95/46/EC of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data.

³⁸ Marc Stauch, Kay Wheat, John Tingle, *Source Book on Medical Law* (2nd edn, Cavendish 2002) 282 ch 5 para 9

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