The responsibility of the doctor

John D J Havard

Throughout history, society's perception of the responsibility of the doctor has been directly related to the importance that the community attaches to relieving pain and suffering and curing disease and disability. It would be difficult to imagine a relationship that affords more scope for exploitation than that which exists between doctor and patient. The need to be able to recognise a properly trained doctor prepared to accept the responsibility inherent in such a relationship was recognised by parliament in 1858 when it set up a statutory body, now called the General Medical Council (GMC), charged with keeping a register of such doctors and with disciplinary powers to deal with those whose conduct fell short of standards required in such a relationship.

The practice of medicine today bears little relation to that in the middle of the last century. The tremendous advances that have taken place have not only enabled doctors to be far more successful in treating disease but also greatly increased their responsibilities. The introduction of new and complex technology has raised all sorts of anxieties about the morality of what doctors are doing or seeking to do, in particular those procedures that are concerned with the beginning and end of life.

As I develop my theme it will become apparent that there are situations in which the profession's own concept of its responsibility both to patients and to society may come into conflict with the law.

The relationship of trust between the doctor and patient requires that, with few exceptions, the patient must consent to any examination, treatment, or other form of medical intervention. The main difficulties that doctors experience in exercising this responsibility are to decide the amount of information to give the patient, the extent to which consent can be implied when the patient cannot give consent, and when the need to obtain consent may be overridden by other considerations such as the force of law.

Consent has become an important legal issue as a result of several cases having been decided in the courts, in which patients have claimed that they did not consent to the treatment or that they were given insufficient information to do so. Generally, doctors who operate on patients without having obtained full consent will not be regarded in law as having committed an assault. But they can be held negligent for having failed to obtain adequate consent if damage to the patient occurs inadvertently as a result of an operation.

There is an interesting difference here between American and English law. Under American law the patient must be informed of every possible adverse consequence of submitting to treatment, whereas under English law the patient needs to be told about only such risks as a responsible body of medical opinion would consider relevant. Such was the position in the Sidaway case, in which the patient had been warned of a small (about 2%) risk of damage to a nerve root in submitting to an operation on the cervical vertebrae but was not warned of a much smaller risk of damage to the spinal cord, which was, unfortunately, what happened during the operation.[1] The House of Lords decided that the surgeon was not liable for failing to warn the patient of such a small risk as he was acting in accordance with recognised surgical practice. If the patient had asked to be told of all the risks of the operation, however, the surgeon would have been held liable for not having warned the patient. The American courts, on the other hand, have ruled that the patient must always be told of all the risks of an operation. The legal view in America is almost unanimous in condemning the Sidaway decision as an unacceptable justification of medical paternalism.[2] On the other hand, the present practice in the United States of warning patients of every possible risk that might conceivably occur is hardly in the interests of the best possible doctor and patient relationship.

HIV tests

The principles underlying implied consent also extend to the use of specimens obtained from patients. Although patients may be assumed to have consented to specimens used for purposes of routine clinical management, this does not apply to HIV tests as patients cannot be assumed to have consented to a test when the results could damage their interests. Although there are no decided legal cases on the issue, a counsel's opinion obtained by the BMA was that the patient must give genuine consent to HIV tests being carried out. Publication of this opinion led to some controversy in the profession as many doctors think that they should have complete discretion to carry out tests on specimens that have been correctly obtained. The issue was resolved by a motion passed at the BMA's 1988 meeting, which confirmed that testing should be carried out only on clinical grounds and with the specific consent of the patient. It did, however, add that there may be individual clinical circumstances when a doctor believes that in the best interests of a particular patient it is necessary to depart from this general rule, but the doctor must be prepared to justify the action before the courts or the GMC. There is also an exception in favour of anonymous prevalence screening carried out to determine the incidence and distribution of the infection.

When the patient is unconscious or otherwise incapable of giving consent, such as mental handicap or immaturity, further difficulties may arise. The responsibility of the doctor in such cases is normally to take whatever steps are necessary to save life or prevent disability. The doctor should not, however, institute treatment or any other procedure beyond that which is necessary to minimise the potential damage to the patient. Occasionally the doctor may be aware that a patient whose condition requires immediate intervention would not have given consent if conscious, such as a Jehovah's witness needing an urgent blood transfusion or a patient who has completed an advanced declaration (living will) that in certain circumstances no treatment should be given. In such cases the doctor should never disregard the wishes expressed by the patient. The primary consideration, however, must always be the clinical condition. The situation of a young otherwise fit patient on the one hand and an elderly patient suffering from a terminal condition on the other is bound to influence the extent

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to which heroic measures are appropriate to save or prolong the life.

Consent in children and the mentally ill

People aged over 16 can consent to medical treatment even if their parents may object.[3] Those under 16 should not normally be treated without attempting to obtain the consent of the parents. When that consent is withheld, or the child is unwilling for the parents to be involved, the doctor should not go ahead with treatment unless satisfied that the child has reached sufficient intelligence and understanding to be capable of consenting.

This was the main point of law to be decided in the Gillick case and is most usually encountered when young girls seek advice on contraception.[4] Then the doctor should try to persuade the girl to agree to her parents being informed before treatment is given. An interesting difference of opinion has arisen between the GMC and the BMA over the responsibility of the doctor who is consulted by a girl and decides that she is too immature to form the necessary consent for contraceptive treatment so that further action cannot be taken without the parent's or guardian's consent. The BMA maintains that if the doctor is unable to persuade the girl to allow her parent or guardian to be involved her confidence must be respected, otherwise, the BMA argues, such girls will be discouraged from approaching a doctor and the opportunity to counsel them will be lost. The GMC on the other hand, advises that if the doctor is not satisfied as to the girl's maturity and ability to understand "he may decide to disclose the information learned from the consultation." The GMC's advice adds that "if he does so, he should inform the patient accordingly, and his judgment concerning the disclosure must always reflect both the patient's best medical interests and the trust the patient places in the doctor." In other words, the responsibility of the doctor to respect the confidence of a consultation by an immature girl about contraception is regarded as absolute by the BMA and as qualified by the GMC.

Special arrangements can be made for the parental objections to treatment (as opposed to consultation) to be overruled in certain cases when children are too immature to form the necessary consent, such as by making a child a ward of court and obtaining the permission of a high court judge. When an operation is necessary to save a child's life, however, the Department of Health recommends that the operation should go ahead provided that the parents, after having had the danger to the child explained to them, confirm that they refuse to agree and a colleague has confirmed that the child's life would be in danger if the operation was withheld.[5] In such circumstances a court of law would be unlikely to rule that the doctor had acted unlawfully in proceeding with the necessary treatment. The views of parents, however, should not be dismissed lightly. There have been cases when parents who are Jehovah's witnesses have rejected their child after the child had been given a blood transfusion against their wishes.

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Victoria Gillick, who failed in her bid to outlaw a health department circular advising doctors that they could give the contraceptive pill or advice on contraception to girls aged under 16 without their parents' consent

Our mental health legislation contains detailed provisions for the examination and treatment of mentally ill or handicapped patients in circumstances in which they cannot be regarded as being able to form the necessary consent. The exercise of these statutory powers is subject to frequent review. The point of law that seems to have given the most difficulty recently is the sterilisation of mentally handicapped women. Pregnancy can be an extremely distressing and confusing experience for such women, who may in any case be incapable of providing care for a child. When other methods of contraception cannot be used sterilisation may be the only alternative to being confined to an institution, which would greatly reduce her quality of life.

If the woman is under the age of 18 application can be made to the court for permission for the operation to take place. When she is over the age of 18 it was thought that the court would have no such powers, and this led to an undesirable tendency to apply to the court just before the 18th birthday. Recently an application was made on behalf of a woman aged 35 who had formed an attachment with another patient, which created a serious risk of pregnancy. Sterilisation was the only possible form of birth control while the relationship, which was beneficial to her, continued. The judge observed that "it was surprising and unsatisfactory that the court had a wide power of a supervisory nature in respect of mental defectives who were minors but no powers over those who were over the age of majority."[6] The judge, nevertheless, declared that the sterilisation would not be unlawful and observed that in such a case "a doctor, if he did nothing, could be said to be negligent.... The law must find an answer." He emphasised that doctors should "not be liable where they acted in good faith and in the best interest of their patients." Subsequently the case went to the Court of Appeal and to the House of Lords where it was held that "the lawfulness of a doctor operating on or giving treatment to, an adult patient disabled from giving consent would depend not on any approval or sanction of a court, but on the question whether the treatment was in the best interests of the patient concerned."[6] In the case of sterilisation of a mentally disabled woman of childbearing age their Lordships thought that "although involvement of the court was not strictly necessary as a matter of law, it was, nevertheless, desirable as a matter of good practice." The House of Lords was in no doubt that the High Court had an inherent jurisdiction in such cases to make a declaration that an operation was lawful.[6]

Requests of the police

The Police and Criminal Evidence Act of 1983 contains provision for intimate body searches to be carried out and for intimate samples to be obtained at the request of a senior police officer (superintendent or above) provided that he or she is satisfied that the person concerned is suspected of involvement in a

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serious arrestable offence and that the sample to be obtained will tend to confirm or disprove such suspicions. Doctors should not take such samples unless the person consents, and they are not required to do so under the Act. Refusal to consent may provide corroboration of evidence subsequently given in court and adverse inferences can be drawn from refusal when there is no good cause for it. Doctors may also be asked to take blood samples under the drinking and driving legislation but again never without the consent of the driver. Penalties are provided for those drivers who unreasonably refuse to provide a sample, and special safeguards are built into the legislation to ensure that the doctor-patient relationship is not compromised.

Home Office and Health Department circulars emphasise that samples can be taken only with the consent of the doctor in immediate charge of the case, and the procedure for obtaining the consent of the patient has to be carefully followed. As failure to follow the appropriate procedure can ruin a successful prosecution, the sample is usually taken by a police surgeon with experience in such cases, and the BMA ruling that it must never be taken by a doctor concerned with the medical management of the case is invariably followed.

Under Scots law a warrant can be obtained from a sheriff for a blood sample to be taken from a detained person without consent and with the use of reasonable force, if necessary, provided it is "in the interests of justice." In 1988 a discussion paper from the Scottish Law Commission on evidence from blood group and DNA tests stated that English law does not allow samples to be taken by force without consent and suggests that "this may be an advantage which is more theoretical than real as, in practice, a person presented with a warrant for the compulsory taking of a sample is more likely to comply."[7] The commission goes on to argue that English law permits force to be used if an arrested person resists search or fingerprinting and that the same considerations should apply to lawful taking of blood under a court order. It suggests that, apart from differences in the degree of invasiveness, the only difference that may be important is that a doctor will take the blood sample, and it says that it would be interested to know if this presents any difficulty.

These contemporary developments in Scotland emphasise a point made repeatedly in the report of the BMA's working party on torture.[8] The evidence received by the working party showed clearly that unless a firm stand is taken early on in the defence of basic principles of medical ethics, doctors can easily become personally involved in unacceptable practices. The principle that, apart from exceptional public health measures, medical intervention should not take place without consent unless it is in the best interests of the person concerned, is particularly important, and the GMC should not feel bound to amend automatically its advice to the profession so as to enable doctors to conform more easily with changes in the law. If the time has not yet arrived for the GMC to take a stand it certainly arrived some time ago in many other countries.

Doctors and torture

Article 1 of the United Nations Declaration of 1975 defines torture as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted . . . on a person for such purposes as obtaining from him or a third person information or confession, or punishing him for an act he has committed or intimidating him or other persons." It goes on to exclude pain and suffering arising from "legal sanctions," apparently so that certain judicial sentences such as those carried out under Islamic law of the removal of limbs, parts of limbs, or other parts of the body will not be regarded as torture. This places doctors requested to give anaesthetics or other treatment in connection with these barbaric punishments in a difficult position. Although such practices must surely be abhorred by doctors, failure to help the prisoner will only increase the suffering of the victim.

The BMA's report defines torture as "the deliberate, systematic or wanton infliction of physical and mental suffering . . . to force another person to yield information, to make confession or for any other reason which is an outrage on personal dignity." Doctors are responsible for not taking part in or facilitating such procedures. The BMA's working party was deeply concerned at reports of doctors having examined torture victims while torture was taking place. There are many authentic reports of doctors taking part in such activities in many countries. While these practices are usually denied by the governments that cause them to be carried out, reliable evidence suggests that some form of torture is practised by the state in the majority of countries.

In the United Kingdom it was proposed as recently

AMNESTY INTERNATIONAL

Amputation victims of torture

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Sir Edmund Compton, who headed the inquiry into allegations of brutality on prisoners in Northern Ireland

as 1972 that doctors should be involved in certain methods of interrogation used in Northern Ireland, including wall standing, hooding, and subjection to noise. A committee of inquiry led by Sir Edmund Compton concluded that these measures were not brutal.[9] Independent medical advice, however, suggested that they were designed not so much to isolate prisoners from each other as a deliberate method of producing mental disorientation and confusion. The Parker committee, which was set up to consider the matter further, concluded that there was no real risk of injury if proper safeguards were applied, and it recommended that a doctor with psychiatric training should be present at all times in the interrogations centre. The role of the psychiatrist would be to warn the controller if he or she felt that the interrogation was being pressed too far.[10] Fortunately, the report was rejected and the interrogation methods, together with any possible involvement of doctors, were stopped.

Doctors are responsible for not being involved or compromised in any measures that may cause harm to people in detention. Evidence given to the BMA's working party from other countries showed that a refusal by doctors to compromise is often effective in the early stages but that once the early stages have been passed unchallenged it may be too late to avoid serious abuse. The problem is to detect the subtle change in relationship that can lead to a doctor's acquiescence in torture. "Each member of the medical profession" the BMA working party emphasised "has a responsibility to make positive judgments . . . as to what are, and what are not, acceptable forms of medical conduct. . . . There is no question that doctors have an individual responsibility to watch for early warning signs of abuse of the profession's skills and bring these to the attention of the whole profession and the public."

Medical confidentiality

Taking personal histories is the basis of modern diagnosis and treatment, and patients answer intimate questions on topics such as previous pregnancies, abortions, suicide attempts, and impotence. Such details are given in the belief that they will not be disclosed to anyone not concerned with the management of the case and detailed records will be kept by the doctors in the knowledge that they will be seen only by people concerned with the clinical management of the patient. Records also include sensitive information about third parties whose consent to disclosure will rarely have been obtained, such as close relatives. Any breach of this confidence will lead to lack of disclosure by the patient, to reluctance by the doctor to keep full records, and even to a refusal by the patient to seek any medical help at all. Appreciating that this information is often obtained from patients at a time when they are highy vulnerable and very dependent on doctors for help is particularly important.

Inevitably there will be cases in which conflict arises over a doctor's duty to the patient and his or her obligation to the community. The classical dilemma of the train driver or airline pilot with previously unsuspected epilepsy is not so much a question of whether to disclose without consent as of how to handle the problem. In most cases reference to a second opinion or enlisting the influence of close relatives will be effective in obtaining consent to disclosure. The commonest problem is unfit car drivers. In such cases the patient, whose interests are always paramount, is more likely to kill or injure himself or herself than anyone else. Attempts to introduce the heavy hand of legislation to override the doctor's discretion in such cases are likely to make matters worse. Doctors know that if they disclose without consent they are always liable to be required to justify their action.

The doctor's responsibility not to disclose confidential information without consent does not extend to information that he or she has to give by statute, such as the notification of certain infectious diseases, attendances by drug addicts, and termination of pregnancy. Statutory disclosure for reasons other than the interests of public health has generally been regarded with considerable suspicion. There is no statutory nor common law requirement that doctors should notify the police when they have reason to believe that a serious crime has been committed. The BMA, however, recognising the risks to the community of withholding information in serious cases has set up a scheme whereby the local unit of the association will advise doctors who have been approached by the police as to whether they should disclose any information. This works well and is highly valued by the police.

Common law

It would be difficult to name a democracy in the Western world that pays less respect to confidential medical information than the United Kingdom. In 1981 the Law Commission recommended the introduction of a statutory offence in the law relating to breach of confidence to include "such usual confidences as arise between doctor and patient" and that it should be extended to reports passing between general practitioners and specialists.[12] Nothing more has been heard of these recommendations during the eight years that have passed since the commission's report was published.

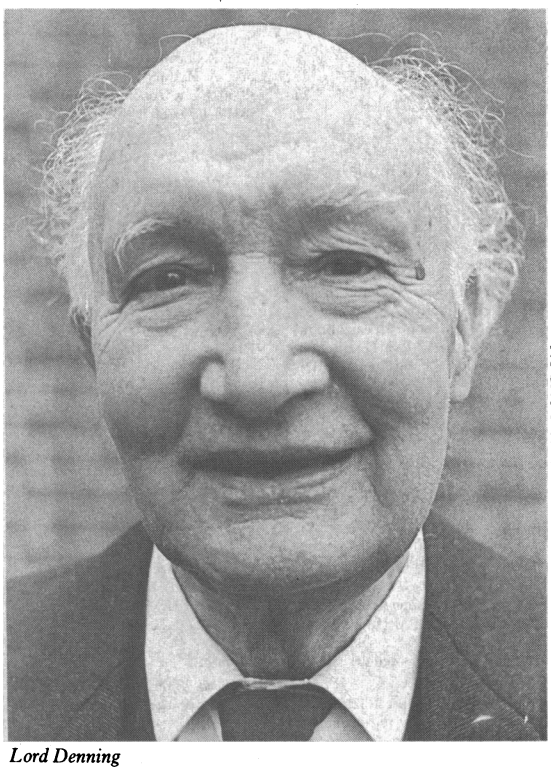
Medical reports associated with child case conferences are likely to contain particularly sensitive information and for this reason access to such records is limited to members of the Social Services Committees in local government who have to deal with such cases. When a lay councillor who was not a member of the committee decided she would like to see one of the medical reports an order was sought prohibiting the council from disclosing the file to her. The divisional court refused to grant this but was overruled by the Court of Appeal. The judgment of Lord Denning, Master of the Rolls, showed a firm grasp of the principles involved and bearing in mind the balance of interests of confidentiality and the need for members of the council to be sufficiently well informed to carry out their duties he stated that, "I am quite clear that the files should be available only to the members of the social services committee and the officers of the social

services department. . . . There is no need whatever for the files to be shown to other members who are not members of the committee and have no particular duty or responsibility in the matter."[12]

The House of Lords, however, reversed the decision of the Court of Appeal and reinstated the decision of the Divisional Court.[13] The House of Lords' decision was based on a detailed review of the previous case law on the "need to know" principle, which has a long history. Nevertheless, it might have been expected that some consideration would have been given to the consequences of applying the law to such a case as this. There was no indication in the speeches of their Lordships of any realisation that their decision could have a disastrous effect on the exchange of information between doctors and social workers in these difficult and sensitive cases. Fortunately the BMA reached agreement shortly afterwards with the local authority associations on a code of practice,[14] which effectively prevents disclosures.

Attempts to restrict access to confidential medical information are rarely supported by our courts. In another case a radiographer had sent detailed confidential case notes to members of a community health council in support of a personal vendetta against a colleague.[15] The radiographer had signed the usual declaration form designed to secure confidentiality, which warned of instant dismissal for unauthorised disclosure of case notes and dismissal followed. An industrial tribunal upheld the radiographer's claim to unfair dismissal and the health authority was strongly advised by counsel not to appeal against the tribunal's decision on the grounds that the tribunal had considered that the community health council would be unlikely to make any of the information public. No account was taken of the fact that the patients concerned were entitled to assume that their confidential case notes would be seen only by those directly concerned with their treatment, and it would seem that undertakings by health care workers not to disclose confidential information to which they are privy are, as often as not, not worth the paper they are written on.

Cases such as these must be regarded as beyond comprehension in those civil law countries that comprise the great majority of the European Community.



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Lord Denning

In those countries the sanctity of medical information is most carefully guarded and disclosure is specifically prohibited under their penal codes, which provide penalties for disclosure. Our government's cavalier attitude to other people's secrets contrasts strangely with the lengths to which it is prepared to go to protect its own.

Privilege from disclosure

Whether confidential medical information should be privileged from disclosure in our courts of law has been considered by both the Law Reform Committee and the Criminal Law Revision Committee, which concluded that no statutory privilege whatsoever should be granted in respect of confidential information passing between doctors and patients. I have examined the arguments used by both committees,[16] and I remain convinced that they cannot be supported.

The Law Reform Committee was faced with the need to reconcile its conclusion with the facts of a contemporary divorce case in which a psychiatrist had been subpoenaed by the party, who was not his patient, to extract from him the fact that his patient had confessed under treatment to having committed adultery.[137] The psychiatrist, not unnaturally, objected but was overruled by the Divorce Commissioner, who compelled him to give evidence. The Law Reform Committee's apologia for this case is profoundly unconvincing. It explains that it was unfortunate that the psychiatrist did not persist in refusing to give evidence in the face of threats by the commissioner, as if he had the point might have been referred to the Court of Appeal when the commissioner's direction to the psychiatrist might have been reversed on grounds that he should have exercised discretion in the public interest not to compel the psychiatrist. "They" (the judges) the committee emphasised, "can be relied upon in future to hold the balance between the Hippocratic oath and the witness's oath to tell the whole truth."[18]

The committee's repeated reassurances that judges would always exercise their discretion in the public interest suffers from two defects. Firstly, it gave no convincing examples of this having happened in practice, and, secondly, it cited no reliable authority for the judges having any power to exercise such discretion in the first place. Indeed, when the point came up for discussion in the House of Lords in a later case Lord Edmund Davies pointed out that there was no reported case in support of the committee's contention that the Court of Appeal might have reversed the Divorce Commissioner's direction to the psychiatrist and that the only way the law could be altered to enable a judge to exercise discretion in this way was by a decision of the House of Lords or by legislation. He added that he was in favour of such a change in the law in respect of confidential medical information.[19] At present, the responsibility of doctors not to disclose information in court without the consent of the patient is afforded no protection whatsoever under English law, irrespective of the public interest that may be at risk.

The Criminal Law Revision committee attempted to justify one of its arguments against allowing psychiatric evidence to be privileged by giving an example based on the supposition that "an unsophisticated person might consult a general practitioner about which a more sophisticated person might consult a psychiatrist" apparently being unaware of the fact that patients, however sophisticated, do not normally get to see psychiatrists unless they have been referred by their general practitioners in the first place.[20] Although the committee examined other systems of law in its review of rules of evidence, no reference was made in

its report to the privilege afforded to confidential medical information in other countries.

The attitude of both committees to the privilege in aid of litigation—that is to information passing between lawyer and client—affords a stark contrast. They regarded the absolute privilege granted to such information as a fundamental principle of our adversarial system of law. Some judges, however, are beginning to have second thoughts as a result of subsequent cases in which its application has clearly resulted in injustice, to such an extent that the Master of the Rolls observed in the Court of Appeal that "there must be something wrong with law." The case was one in which a woman was unable to prove the cause of brain damage to her child because of the privilege in aid litigation, and the Court of Appeal reached its conclusion "with undisguised reluctance."[21]

Unfortunately, membership of our own law reform committees, unlike those in other commonwealth countries, is usually restricted to lawyers. Significantly, the Chairman of the Australian Law Reform Commission, which consults closely with the medical profession, has observed that "effective medical treatment of the public is at least as important as the due administration of justice" and "that it should be given equal treatment and protection against non-consensual disclosure to the courts."[22]

Conclusion

I am aware of the wide range of responsibilities of the doctor that I have failed to cover. My main purpose has been to examine the extent to which the law impinges upon those responsibilities and to me the issues of consent and confidentiality afforded the best illustration, as well as being of considerable topical interest. I can only hope that the points that I have made about some of the more important responsibilities of doctors will help to convince the reader that the subject needs to be far better understood by those responsible for formulating our laws and those who administer them.

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