

## DO NO HARM—DO PATIENTS HAVE RESPONSIBILITIES TOO?

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### I. INTRODUCTION

TOWARDS the end of his judgment in *R. v. Collins and Ashworth Hospital Authority ex p. Brady*,<sup>1</sup> Kay J. (as he then was) delivered the following homily:<sup>2</sup>

... it would seem to me a matter of deep regret if the law has developed to a point in this area where the rights of a patient count for everything and other ethical values and institutional integrity count for nothing.

The context of his remark was his rejection of Ian Brady's application for judicial review of Ashworth Hospital's decision to force-feed him, and break his hunger strike. Brady contended that he was mentally competent and retained the right to refuse to eat. Prior case-law had confirmed that a mentally competent prisoner cannot lawfully be force fed.<sup>3</sup> Moreover, patients, detained under the Mental Health Act 1983 as Brady was, can in theory, only be treated against their will where such treatment constitutes treatment for that mental disorder.<sup>4</sup> A detained patient retains the right to reject other treatment, providing that he has the requisite mental capacity to make the particular treatment decision in question.<sup>5</sup>

Kay J. held (*inter alia*) that section 63 of the Mental Health Act justified force-feeding Brady as treatment for his mental disorder<sup>6</sup> and further found that Ian Brady was not mentally competent to make decisions about accepting or rejecting food. The judge agreed

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<sup>1</sup> [2000] Lloyds Rep. Med. 355.

<sup>2</sup> *Ibid.*, at p. 367.

<sup>3</sup> *Secretary of State for the Home Department v. Robb* [1995] Fam. 127.

<sup>4</sup> Mental Health Act 1983, s. 63. It must be acknowledged that the courts have incrementally adopted an extraordinarily broad definition of what constitutes treatment for mental disorder; see *B. v. Croydon Health Authority* [1995] Fam. 133, CA; *Tameside and Glossop Acute Services Trust v. CH* [1996] 1 F.L.R. 762.

<sup>5</sup> *Re C (adult: refusal of treatment)* [1994] 1 W.L.R. 290. See now the Mental Capacity Act 2005, s. 2.

<sup>6</sup> For a full analysis of the several aspects of the judgment see P. Fennell (Commentary), *R. v. Ashworth Hospital Authority ex p. Brady* (2000) 8 Medical Law Review 251.

with experts instructed by the hospital that Brady's personality disorder "critically compromised his capacity in relation to decisions touching upon his refusal of food".<sup>7</sup> Brady "eschewed the weighing information and the balancing of risks and needs to such an extent that ... his decisions on food and force-feeding have been incapacitated".<sup>8</sup> It was lawful and justifiable to feed him in his best interests given his mental incapacity. Nonetheless in the quotation with which I began, the judge appeared to signal that, even had he found Brady to be mentally competent, he might still have ruled that force-feeding him was lawful, justifying the violation of Brady's autonomy by reference to other ethical values.

*Brady* prompts a number of questions. (1) The judgment further fuelled debate on that "most litigated" of sections of the Mental Health Act 1983, s. 63.<sup>9</sup> But did Kay J. also stretch the rules on capacity to deprive Brady of his residual autonomy, driven perhaps by the horrific nature of Brady's crimes and history?<sup>10</sup> Could he be accused of manipulating the rules on capacity to arrive at an outcome which most would welcome? (2) Should the judge face an even more serious charge of blasphemy—attacking the great god Autonomy? I shall not address the first of these questions directly. I limit myself to His Lordship's suggestion that Autonomy is not the only god in the ethical, or indeed the legal, pantheon. I argue that Kay J. *may* be right. The domination of one of many ethical principles is disturbing. Patients' rights were neglected for much of the twentieth century. Judges were too ready to endorse doctors' judgment of what was best for the patient.<sup>11</sup> The past two decades have arguably over-corrected the balance. Patients, people, have responsibilities to others which we neglect at our peril. My difficulty is that while articulating the *ethical* responsibilities of patients seems imperative, determining when the law should step in to enforce such responsibilities is much more difficult. Hence my dithering statement Kay J. *may* be right.

Beauchamp's and Childress's four principles of biomedical ethics, are well known—respect for autonomy, non-maleficence, beneficence and justice.<sup>12</sup> As happens to any successful formulation of principles, debunking the four principles has become a popular

<sup>7</sup> *Ibid.*, at p. 365.

<sup>8</sup> *Ibid.*, at p. 366.

<sup>9</sup> See note 6 above.

<sup>10</sup> S. Foster, "Force Feeding, Self-determination and the Right to Rie" (2000) 150 N.L.J. 857.

<sup>11</sup> See, for example, the speech of Lord Diplock in *Sidaway v. Board of Governors of Bethlem Royal and the Maudsley Hospital* [1985] A.C. 871, 894–5. And see M. Brazier, "Patient Autonomy and Consent to Treatment: The Role of the Law?" (1987) 7 L.S. 169.

<sup>12</sup> T.L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 5th ed. (Oxford 2001).

pastime.<sup>13</sup> Nonetheless, Beauchamp and Childress have profoundly influenced modern thinking about how doctors should conduct themselves. My doctors must respect *my* autonomy, do *me* no harm, seek to do good to *me* and treat *my* claims with justice. Health professionals must behave ethically. But what of the patient? Do I have a reciprocal duty to respect my doctor's autonomy? Should I accept that my responsibility to do no harm, to seek to do good and to recognise justice may sometimes mean conceding that my claims to what I want in terms of health and health care are weaker than those of others? I shall argue that people have ethical responsibilities which do not disappear simply because they are ill, because they become patients. Draper and Sorrell<sup>14</sup> have made a cogent case that patients do have ethical responsibilities. They contend "Medical Ethics is one-sided. It dwells on the ethical obligations of doctors to the exclusion of those of patients".<sup>15</sup> In this paper, I join them in attempting to redress that imbalance. I do so recognising that in this paper I address only a fraction of either the philosophical debates or the practical questions arising from an attempt to explore whether patients have responsibilities too. In particular, I avoid the debate about the extent to which a person's responsibility for her own disease, for example liver disease caused by alcohol abuse, affects her entitlement to treatment. That debate demands several papers of its own.

## II. AUTONOMY OVERSOLD?

Beauchamp and Childress formulate *four* principles. Three of their four ethical principles have legal counterparts. Respect for autonomy translates into the right of self-determination and is often extended to embrace a right to privacy.<sup>16</sup> Non-maleficence echoes the law's duty of care—do no harm. Justice ought to be central to the law and plays its role in legal claims relating to access to health care or allocation of resources. Beneficence alone may lack its legal "twin". Nonetheless, "the law and ethics of medicine are dominated by one paradigm—the autonomy of the

<sup>13</sup> See, for example, K. Clouser and B. Gert, "A Critique of Principlism" (1996) 15 *Journal of Medical Philosophy* 219. For a more measured judgment of "principlism" see J. Savulescu *et al.*, "Festschrift Edition of the Journal of Medical Ethics in Honour of Raanan Gillon" (2003) 29 *Journal of Medical Ethics* 265–312.

<sup>14</sup> H. Draper and T. Sorrell, "Patients' Responsibilities in Medical Ethics" (2002) 16 *Bioethics* 335–352. And see J.K. Mason and G.T. Laurie, *Law and Medical Ethics*, 7th ed. (Oxford 2005) at pp. 4–10.

<sup>15</sup> *Ibid.* at p. 335.

<sup>16</sup> See *Campbell v. Mirror Group Newspapers Ltd.* [2004] 2 A.C. 457, H.L. and see P. Case, "Confidence Matters: The Rise and Fall of Informational Autonomy in Medical Law" (2003) 11 *Medical Law Review* 208.

patient”.<sup>17</sup> At the end of the twentieth century, autonomy somehow acquired paramountcy—a trump card beating all the other principles. It is simple to see why. The legal mechanism for enforcing at least part of the notion of respect for autonomy is easy to discover and easy to operate—at a superficial level at any rate. The ancient trespass torts designed to protect bodily integrity do service as the bodyguard of autonomy. They serve only a partial role. Thou shalt not trespass on my body enables me to say no. However in today’s debates on access to health care, autonomy is prayed in aid much more widely. *My* choices about my health care should be met in full. What I want should be delivered. A health service should provide the service the consumer demands. And the doctor must deliver what the consumer-patient demands. When I summon the plumber to install a new bath, he will be unlikely to insist that I choose a bath other than the disgusting puce monstrosity that I have fallen in love with. Nor will he take it upon himself to suggest that it is unutterably selfish of me to select a bath far too small and uncomfortable for my much taller husband.

Just as autonomy has gradually but inexorably extended to become a claim of a right to health care, and the health care of your choice, so it is used as the template for decision-making in circumstances where it may be mythical because the purported choice is in no sense an autonomous choice. Yet reflection on what that simple word means is often lacking. Onora O’Neill<sup>18</sup> has powerfully demonstrated the facile way in which autonomy is too often invoked. A right to respect for autonomy means more than simply “I must be given what I want”.

Faden and Beauchamp<sup>19</sup> offer an interesting definition, identifying autonomy with “... privacy, voluntariness, self-mastery, choosing freely, choosing one’s own moral position and *accepting responsibility for one’s choices*”. To this list O’Neill would add “self-control” and “self-determination”.<sup>20</sup> Unfettered, non-reflective choice, the satisfaction of preferences, is not, within such definitions, the essence of autonomy. Self-mastery and self-control entail the requirement at least to consider self-sacrifice.

<sup>17</sup> See C.E. Schneider, *The Practice of Autonomy: Patients, Doctors and Medical Decisions* (Oxford 1998) cited in G.M. Stirrat and R. Gill, “Autonomy in Medical Ethics After O’Neill” (2005) 31 *Journal of Medical Ethics* 127–30.

<sup>18</sup> O. O’Neill *Autonomy and Trust in Bioethics* (Cambridge 2002). And see O. O’Neill, “Some Limits of Informed Consent” (2003) 29 *Journal of Medical Ethics* 4–7; O. O’Neill, *A Question of Trust* (Cambridge 2002).

<sup>19</sup> R. Faden and T. Beauchamp (in collaboration with N.M.P. King), *A History and Theory of Informed Consent* (Cambridge 1986) p. 7.

<sup>20</sup> See *Autonomy and Trust in Bioethics*, note 18 above, at p. 22.

Responsibility for one's choice demands consideration of how those choices will affect others.

Autonomy belatedly acquired its own mastery in English law.<sup>21</sup> Ironically just as lawyers hang out the flags for autonomy our philosopher colleagues cry to us to keep the champagne on ice. The celebrations could go sour. O'Neill quotes the guru of American bioethics, Daniel Callahan: "Nothing has exasperated me so much as the deference given in bioethics to the principle of autonomy".<sup>22</sup> Should Callahan and O'Neill be burned for heresy? There may be no shortage of volunteers to light the fire.

I embark on any analysis of patients' responsibilities with trepidation. First, it is resonant of the populist authoritarian approach of certain tabloid newspapers. Second, the cry of "not just rights but responsibilities too" has become superficial and fashionable—a pale ethical reflection of the political third way.<sup>23</sup> Finally and most importantly, I do not seek a return to the Dark Ages where the patient's duty was to be patient. In a relationship where the recipients of medical care were infantilised, patients' responsibilities seem to me to be of a much lesser order. Less is expected of children than adults. It is empowerment of patients which brings responsibilities.<sup>24</sup>

Let us consider what those responsibilities might entail. The four principles proposed by Beauchamp and Childress, the backbone of critical medical ethics, derive from more general philosophical debate. Moral obligations to respect the autonomy of others, to do no harm, to seek to do good and to deal justly with others attach to each and every one of us in our professional and our daily lives. Hume argues<sup>25</sup> that we incur obligations to benefit others from the nature of the society in which most of us choose to live: "All our obligations to society seem to imply something reciprocal. I receive the benefits of society and therefore ought to promote its interests".

That statement has especial significance within a publicly funded health care system. A *National Health Service* assumes a model of collaboration between doctors and patients, between the well and the sick, and between patients and patients. Very few patients in the United Kingdom opt out of the NHS altogether, buying every

<sup>21</sup> See in particular *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam. 95, 102, CA, *Airedale NHS Trust v. Bland* [1993] A.C. 789, HL; *St George's NHS Hospital Trust v. S* [1999] Fam. 26, C.A.

<sup>22</sup> Daniel Callahan "Can the Moral Commons Survive Autonomy?" (1996) *Hastings Centre Report* 41–2.

<sup>23</sup> For example, the "respect agenda", the key theme of the Queen's Speech in May 2005: see *The Times* 18 May, 2005.

<sup>24</sup> Reflecting perhaps a tentative endorsement of communitarian medical ethics, see D. Callahan, "Principlism and Communitarianism" (2003) 29 *Journal of Medical Ethics* 287.

<sup>25</sup> David Hume "Of Suicide" in *Essays, Moral, Political and Literary*, ed. Eugene Miller (Indianapolis 1985), 577–89.

item of healthcare in a free market. Even were self-funding of health care to become much more common, health is not a purely personal concern. Unless I become an anchorite, my health or ill-health impacts on others with whom, voluntarily or involuntarily, I share my life. To take a crude example, if I deliver a lecture infected with active pulmonary tuberculosis and cough regularly without even placing my hand before my mouth, one or more of my audience may contract tuberculosis. My right to make my own decisions about whether to accept treatment, and to conform to medical advice *not* to go to work and risk spreading a potentially deadly disease, must be subject to a duty not to endanger others' health, not do harm.

Nor need examples be quite so dramatic or unusual. Reflect on the responsibilities of parents of young children. The potential harm occasioned to a child by the loss of a parent, the trauma of bereavement and consequent loss of parental care suggests a moral obligation on parents to care for their own health, an obligation not a million miles removed from their legal obligation to care for their children's health. Lone parents' obligations are arguably the greater because the consequences to the child are greater. Consider the case of a widowed father refusing surgery to remove a melanoma on his face because his good looks and sexual allure would be at stake. He prioritises a short life but a merry one. In exercising his right of self-determination, his absolute right to choose, I would argue that he acts unethically if he acts without regard to the consequences of his choice to his children. The dependency of others, be they young children, elderly parents or simply those who love you, creates moral obligations towards them. The weight of those obligations will be conditioned by the individual's personal circumstances. The only child of a widowed mother bears a greater burden than one of several siblings. That may not be *fair*, but fairness is not a moral entitlement.

Reciprocal ethical obligations extend into every area of our lives. They are not unique to matters of health. Let me propose a thought experiment. At dinner in the Middle Temple, the unthinkable occurs. There is an insufficient supply of the main course to be served at dinner. Guests (equally unthinkably) are invited to serve themselves. Recognising that there are four people still to receive their portions and barely enough for two healthy adults, X greedily scoops virtually all that is left on to her plate. No doubt she will be considered rude and discourteous. X has behaved badly and displayed a total disregard for etiquette. Alter the context. Together with the same three unfortunates whom X deprived of dinner, X is later stranded on a boat adrift in the

Atlantic, desperately praying for rescue. The four agree to ration their water supply so that it should last for two days, X guzzles the lot. Has X simply shown bad manners or acted unethically? May she even have acted unlawfully?

### III. ETHICS OR ETIQUETTE?

Much of what traditionally passed for medical ethics until about 25 years ago was in reality only *etiquette*.<sup>26</sup> It was about good, gentlemanly behaviour. The influence of the Manchester physician, Thomas Percival, with his emphasis on the benevolent and gentlemanly physician endured.<sup>27</sup> Gillon and others criticised what they perceived to be the insubstantial content of ethical guidance for doctors.<sup>28</sup> Etiquette became a devalued value.<sup>29</sup> Manners are not principles and etiquette alone is not enough. Nonetheless in exploring patients' responsibilities, etiquette offers a starting point because true courtesy derives from respect and regard for others, and may be seen as at least a precursor of moral obligations and consequently legal duties. If we move from abstractions to the reality of the NHS today, some of the responsibilities the NHS already seeks to place on patients initially stem from good manners.<sup>30</sup> Visit any surgery or hospital clinic in England today and you will see notices of the following kind, notices undreamed of 50 years ago. They state that patients who are violent or abusive to staff may be refused treatment. Telephone conversations may be recorded and abusive language used to receptionists may result in expulsion from the general practitioner's list. Other notices spell out the numbers of missed appointments and the consequent lost opportunity to the NHS and other patients. The Royal College of Surgeons sets out its own code of patients' responsibilities. They range from injunctions to treat staff and other patients with courtesy (etiquette) to requirements to understand pressure on resources, to take medicines as instructed and "accept responsibility for your own actions".<sup>31</sup>

<sup>26</sup> See R. Gillon *Philosophical Medical Ethics* (Chichester 1996) especially Chapter 5; R. Gillon "The Function of Criticism" (1981) 283 B.M.J. 1633.

<sup>27</sup> Thomas Percival, *Medical Ethics* (1808); see C.D. Leake (ed.), *Percival's Medical Ethics* (Baltimore 1927).

<sup>28</sup> An attack which is well justified and substantiated by simply considering the brevity and contents of the advice offered to medical practitioners by the General Medical Council in 1985; see GMC "Bluebook", *Professional Conduct: Fitness to Practise* (April 1985).

<sup>29</sup> See BMA, *Philosophy and Practice of Medical Ethics* (1988), p. iii noting that "the word Etiquette has virtually disappeared from current usage" and preferring the term 'Professional Behaviour'.

<sup>30</sup> See Draper and Sorrell, note 14 above, 340–341.

<sup>31</sup> *Patients' Rights and Responsibilities* (Patient Liaison Group, 2001) RCS ([www.rcseng.ac.uk](http://www.rcseng.ac.uk)).

Few would disagree that it is discourteous to demand an appointment without a please or thank you, or to revile the receptionist who explains that no appointment is available today. Most people would regard the person who simply did not turn up to see her GP the next day because her backache has gone as thoughtless. Would we think they acted immorally, or unethically? Threatening the receptionist with violence crosses the borderline to illegality not just immorality. Reflecting on the consequences of missed appointments transforms mere thoughtlessness into a more serious wrong. The patient recovered from her backache may well have deprived someone more seriously sick of prompt attention.

These apparently trivial examples tease out the difficulty of articulating the responsibilities of patients in the context of health care. Pain, fear and sickness do not see us at our best. Crippling backache and a consequent bad night may contribute to untypical rudeness while telephoning for an appointment to the gatekeeper acting for the professional who can relieve that pain. The sudden illness of a child may be the cause not just of missing one's own appointment, but of totally forgetting about that appointment. Inflexible appointments systems used to result in appointments it was hard to meet. New computerised systems allowing patients to choose their own appointments often break down. The discourtesy of NHS staff may prompt a similar response. Justification and excuses abound for trivial bad behaviour by patients. The very need to seek excuses concedes the wrongness of the behaviour. If such behaviour were not wrong there would be no call for pleas in mitigation.

#### IV. COURTESY, BENEFICENCE AND THE LAW

A moral duty to behave with courtesy and consideration in sickness, as much as in health, may be perceived as a mere pious aspiration. What must be examined is whether such an aspiration could or should create concrete legal obligations incumbent on patients in their dealings with doctors, with each other, and with the community as a whole. There can be no doubt that the common law endorses a universal moral obligation to *refrain* from causing harm to others—to do no harm. Lord Atkin's words are burned into every law student's heart:<sup>32</sup>

The rule that you are to love your neighbour becomes in law, you must not injure your neighbour; and the lawyer's question, Who is my neighbour? receives a restricted reply. You must take reasonable care to avoid acts or omissions which you can

<sup>32</sup> *Donoghue v. Stevenson* [1932] A.C. 562, 580.



reasonably foresee would be likely to injure your neighbour. Who, then, in law is my neighbour? The answer seems to be—persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or *omissions* which are called into question.

Read literally, Lord Atkin appeared to give legal force not just to non-maleficence, but to beneficence as well. I must have regard for others affected by what I do both in relation to actions I choose to pursue and in what I choose not to do. The chequered history of the neighbour principle within the context of the development of the duty of care in negligence is outwith this paper.<sup>33</sup> However one special feature of the common law must be noted. As yet in English law there is no duty to rescue—no positive obligation of beneficence.<sup>34</sup> I cannot be obliged to intervene to assist others with whom I have no pre-existing special relationship. It is trite law to say that the off duty doctor who fails to respond to the call “is there a doctor in the house” at the theatre incurs no legal liability if she sits tight in her seat. However straightforward and undemanding the intervention required of her may be, she has no legal obligation to intervene. Absent a prior relationship with the dying man her “pure” omission may not be legally questioned. She may however face disciplinary proceedings for breach of her ethical obligations as a health professional.<sup>35</sup>

An undue emphasis on *health* professionals’ duty to be a good Samaritan distorts the central question about whether any citizen owes others such a duty. Should I collapse at the lectern while delivering a lecture in Tort with the obvious symptoms of a cardiac arrest, each one of my audience holds my fate in her hands. Dial 999 and my life may be saved. Walk out of the lecture theatre and my students may sleep easy in their beds. At least they need not concern themselves with the threat of prosecution, or the prospect of a Fatal Accidents claim brought by my daughter. Revisit Lord Atkin’s neighbour principle. Who in this example could be more closely and directly affected by that callous act in abandoning me to die than I, and my dependants? One beneficial consequence of an emphasis on rights is that the English courts may well (at some

<sup>33</sup> See *Clerk and Lindsell on Torts*, 19th ed. (London 2006), pp. 383–414.

<sup>34</sup> See *Smith v. Littlewoods Organisation Ltd.* [1987] A.C. 241, 271; and see A. McCall Smith “The Duty to Rescue and the Common Law”, in M. Menlowe and A. McCall Smith (eds.), *The Duty to Rescue* (Aldershot 1993); B. S. Markesinis “Negligence, Nuisance and Affirmative Duties of Action” (1989) 105 L.Q.R. 104 119–124; J. Ratcliffe (ed.), *The Good Samaritan and the Law* (Garden City 1966).

<sup>35</sup> General Medical Council *Good Medical Practice* (GMC 2001), par. [9]: “In an emergency, wherever it may arise, you must offer anyone at risk the assistance you could reasonably be expected to provide.”

point) have to revisit a duty to rescue. A legal system which imposes no responsibility to provide even easy rescue may not conform to Article 2 of the Human Rights Convention. My right to life may impose duties on my fellow citizens.<sup>36</sup>

Even should a minimal Samaritan duty (and thus beneficence) ultimately be endorsed by the common law or statute, it will not take us far in an exploration of patient responsibilities. Distinction will still have to be made between *acts* causing harm to others, *omissions* resulting in harm to others, and *demands* endangering or harming others.

#### V. DO NO HARM—NON-MALEFICENCE

The first case, that is *acts* harming others, looks relatively straightforward. Being ill does not absolve a person of her normal legal and moral responsibilities to other people unless the very nature of that illness deprives her of mental capacity.<sup>37</sup> If I ignore medical advice and expose my students involuntarily to the risk of contracting tuberculosis my conduct is morally indistinguishable from assault. Legal niceties once beset the exact nature of any crime committed.<sup>38</sup> Was the projection of droplets containing tuberculosis equivalent to dousing you with water or spitting on you, thus establishing the contact required for assault?<sup>39</sup> Other modes of disease transmission clearly fell outside the ambit of assault. The patient infected with hepatitis by a seropositive surgeon, or the lover contracting HIV from her partner, consented to the crucial contact which resulted in their illness. For over a century *R. v. Clarence*<sup>40</sup> appeared to rule out criminal liability in such scenarios. The victim's consent to the relevant physical contact was not vitiated by her ignorance of the risk of contracting disease. The extraordinary facts in *R. v. Gaud*,<sup>41</sup> where a surgeon had fraudulently concealed that he was a hepatitis carrier for years, prompted the courts to look for redress in the ancient crime of causing a public nuisance. In *HM Advocate v. Kelly*<sup>42</sup> a Scottish

<sup>36</sup> *Hughes v. United Kingdom* Application No. 11590/85 (European Commission on Human Rights). And see Markesinis, note 34 above, 120 on the growing influence of comparative law.

<sup>37</sup> See M. Brazier and J. Harris, "Public Health and Private Lives" (1996) 4 *Medical Law Review* 171.

<sup>38</sup> See S. H. Bronitt, "Spreading Disease and the Criminal Law" [1994] *Crim. L. R.* 21; K. M. Smith, "Sexual Etiquette, Public Interest and the Criminal Law" [1991] 42 *N.I.L.Q.* 309.

<sup>39</sup> *Pursell v. Horn* (1832) 8 A. & E. 602.

<sup>40</sup> [1888] 22 Q.B.D. 23; and see *Hegarty v. Shine* (1878) 14 Cox C.C. 124.

<sup>41</sup> (Unreported). See M. Mulholland, 'Public Nuisance—a New Use for an Old Tool' (1995) *Professional Negligence* 70.

<sup>42</sup> (2001) High Court of Judiciary, Glasgow; discussed in J. K. Mason and G. T. Laurie, note 14 above, 34–36. And see J. Chalmers "The Criminalisation of HIV Transmission" (2002) 28 *Journal of Medical Ethics* 160.

court convicted a man who infected his lover with HIV of culpably and recklessly endangering her health. *R. v. Dica*<sup>43</sup> confirmed that, in principle, English law endorses and enforces an obligation not to impose risks of disease on unsuspecting others.

*Dica* is a complex decision. The accused was convicted in October 2003 on two counts of inflicting grievous bodily harm, contrary to s. 20 of the Offences Against the Person Act 1861, on lovers whom he infected with HIV. The Judge at first instance ruled (*inter alia*) that any consent on the part of the victims to the risk of contracting HIV, and thus their knowledge or otherwise of the accused's seropositive status, was irrelevant and provided no defence. He relied on *R. v. Brown*<sup>44</sup> to maintain that the women had no capacity to consent to such serious harm. Following the Judge's ruling the accused chose not to give evidence and the question of whether his lovers knew of his HIV positive condition was not left to the jury. The Court of Appeal quashed the conviction and ordered a retrial. Consensual acts of sexual intercourse do not become unlawful "merely because there may be a known risk to the health of one or other participant".<sup>45</sup> Any such principle would be ludicrous and unworkable. The devout Roman Catholic wife who risks death or serious illness in pregnancy could see her husband in the dock. As Judge L.J. said, "interference of this kind with personal autonomy, and its level and extent, may only be made by Parliament".<sup>46</sup> Even then, would such a radical form of "protectionism" violate the European Convention of Human Rights?

The key question in *Dica*, the appeal court ruled, was whether the victims had consented to the risk of contracting HIV. To consent they must first be aware of the accused's condition, though knowledge alone would not normally establish consent. Absence of consent to such a risk did not vitiate consent to intercourse. *Dica* was not guilty of rape. Inflicting serious bodily harm is no longer an offence parasitic on assault.<sup>47</sup> No assault need to be proven, simply the imposition on the victim of serious harm to which she has not consented.

The judgment of the Court of Appeal in *Dica* went beyond the proposal in the Draft Offences Against the Person Bill<sup>48</sup> to

<sup>43</sup> [2004] Q.B. 1257, C.A. For an excellent critical analysis of *R. v. Dica* see M. Weait, "Criminal Law and the Sexual Transmission of HIV: *R. v. Dica*" (2005) 68 M.L.R. 121–139.

<sup>44</sup> [1994] 1 A.C. 212, H.L.

<sup>45</sup> *R. v. Dica* [2004] Q.B. 1257, 1271.

<sup>46</sup> *Ibid.*, at 606.

<sup>47</sup> See *R. v. Ireland*; *R. v. Burstow* [1998] A.C. 147 H.L.

<sup>48</sup> The draft Bill moulders on the shelves of the Home Office; see A. Ashworth, *Principles of Criminal Law*, 4th ed. (Oxford 2003), 338–9. The government rejected Law Commission proposals that new offences of intentional and reckless injury should include both intentional

criminalise only *intentional* transmission of disease. The essence of the crime in *Dica* is the reckless transmission of the disease to others who have not consented to run the risk in question. Judge L.J. endorsed John Spencer's cogent claim:<sup>49</sup>

To infect an unsuspecting person with a grave disease you know to have, or may have, by behaviour you know involves a risk of transmission, and that you know you could easily modify to reduce or eliminate the risk, is to harm another in a way that is both needless and callous. For that reason criminal liability is justified unless there are strong countervailing reasons.

Discussion of criminalisation of disease transmission has all too often focused solely on HIV transmission via sexual intercourse. Commentators<sup>50</sup> have argued that invoking the criminal law will stigmatise HIV positive people, will be counter-productive because it will deter individuals from seeking testing and counselling, and will do little to protect public health. Weait<sup>51</sup> cogently argues that prosecutions based on *Dica* risk discrimination against "certain categories of people—the Black African refugee, the gay or bisexual man, the IV drug user". He concludes that criminalisation of HIV transmission "reinforces social stigma against those who, though they may have infected others, are also people who have themselves been infected".

Others<sup>52</sup> have argued that the primary responsibility to protect oneself against sexually transmitted disease should be personal. I should ensure my lover uses a condom unless he proves beyond reasonable doubt that he is in good sexual health. But what if he lies? And the patient endangered by a surgeon with HIV has no means of self-protection. The student contracting tuberculosis when I cough over her is at my mercy. In the context of this paper, *Dica* enforces the fundamental principle of do no harm, while at the same time illustrating the difficulties inherent in translating ethical responsibilities into legal obligations.<sup>53</sup> That some kind of legal responsibility should attach to those who recklessly fail to

and reckless disease transmission; see *Offences Against the Person and General Principles* (Law Com. 218, 1993) and the government's response *Violence: Reforming the Offences Against the Person Act 1861* (Home Office, 1998). And see Weait, note 43 above, at 129–30.

<sup>49</sup> J. R. Spencer, "Liability for Reckless Infection" (2004) 154 N.L.J. 384, 448; "Retrial for Reckless Infection" (2004) 154 N.L.J. 762.

<sup>50</sup> See (*inter alia*) R. Porter, "History Says No to the Policeman's Response to AIDS" (1986) 293 B.M.J. 1589; P. Old and J. Montgomery, "Law, Coercion and Public Health" (1992) 304 B.M.J. 851. And see the extensive literature cited by Weait, note 43 above, at footnote 1.

<sup>51</sup> See note 43 above, 134.

<sup>52</sup> See, for example, the discussion in R. Bennett, H. Draper and L. Frith, "Ignorance is Bliss? HIV and Moral and Legal Duties to Forewarn" (2000) 26 Journal of Medical Ethics 9.

<sup>53</sup> Difficulties exacerbated by the subsequent decision in *R. v. Konzani* [2005] EWCA Crim 706; see H. Law, "Court of Appeal: Offences Against the Person: Reckless Transmission of HIV" (2005) 69 Journal of Criminal Law 385.

safeguard others from, at least, the risk of serious disease<sup>54</sup> seems self-evident. Should a pandemic transmitted via close contact alone reach the UK, draconian regulations curbing individual liberty are highly likely.<sup>55</sup> Consideration in advance of such a crisis of just how the law views the responsibilities of “dangerous” patients and how autonomy is balanced against non-maleficence will produce a fairer and more coherent response to such a crisis.

Criminalisation of disease transmission is not novel—not solely an invention in *Dica* or exclusively a response to HIV. It has long been an offence to expose others to the risk of contracting a notifiable disease in a public place.<sup>56</sup> Public health legislation authorises the detention of critically infectious individuals suffering from diseases like tuberculosis. I could be deprived of my liberty if I refuse to comply with treatment and insist on endangering my students.<sup>57</sup> Yet arguably once immured in hospital, that same legislation does not authorise treatment against my will.<sup>58</sup> An outbreak of infection at a unit treating patients with tuberculosis is said to have resulted from cross infection by a detained patient refusing treatment. On his release that same patient is alleged to have gone on to infect others.<sup>59</sup> Is it logical to say X may be deprived of liberty but not prevented from endangering fellow patients? Is solitary confinement preferable to any violation of bodily integrity? Might Kay J. be right in saying autonomy should sometimes be weighed against competing principles?

The full ramifications of criminalisation of disease transmission are endless and I only want to establish a basic principle within this paper. If I retain the mental capacity to exercise my right of self-determination in relation either to my decisions about my medical treatment or conduct, I continue to bear responsibility for the consequences of my decisions. I cannot have it both ways. I cannot assert my right to autonomy and deny any personal responsibility for my harmful conduct.

<sup>54</sup> The Law Commission in their proposals on reform of offences against the person suggested that criminal liability should not necessarily be confined to diseases serious in themselves. Reckless transmission of more minor illnesses such as ordinary influenza or the common cold might properly attract liability if the accused knew that the victim was especially susceptible to serious harm should he contract that illness, *e.g.*, a cancer patient whose immune system is compromised during chemotherapy; see Law Commission Report No. 218 (note 48 above). And see J. Harris and S. Holm, “Is there a Moral Obligation not to Infect Others?” (1995) 311 B.M.J. 1215.

<sup>55</sup> S. 13 (1) of the Public Health (Control of Diseases) Act 1984 grants the Secretary of State wide powers to make regulations “with a view to the treatment of persons affected with any epidemic, endemic or infectious disease and for preventing the spread of such diseases”.

<sup>56</sup> Public Health (Control of Diseases) Act 1984, s. 17.

<sup>57</sup> See Brazier and Harris, *op cit.*, note 37 above.

<sup>58</sup> See A. Grubb (ed.), *Kennedy and Grubb’s Medical Law*, 3rd ed. (London 2000), 909.

<sup>59</sup> See “TB Timebomb Infects 12” *The Mail on Sunday* 8 May, 2005.

## VI. NON-FEASANCE AND NON-MALEFICENCE

What of omissions to consider others' interests, failing to act to prevent a preventable harm? Does the law have a role where non-maleficence involves non-feasance? The question is too large to do more than scratch its surface. Autonomy in its manifestation as privacy provides an illustration of the problem. I consider a particular example in relation to genetic information.<sup>60</sup> Every day more and more information about our own health becomes accessible to us. The explosion in genetics will enable us to glimpse our possible future. It also enables us in some cases to change that future. Knowing that I have a genetic predisposition to bowel cancer enables me to take steps to reduce my risk, even to reduce my risk to a lesser level than friends who have no such predisposition. Genetic information is however not exclusively mine.<sup>61</sup> I share my genetic make-up with my family. Information about me is relevant to them. In disclosing information about myself, I also reveal information about them.<sup>62</sup>

If I discover that I carry a gene predisposing me to potentially malignant polyps on the bowel, what are my responsibilities to other family members? Regular screening from a relatively early age and swift removal of the polyps minimise the risk. If I carry the gene so may my siblings and children. The sooner they seek screening, the lower the risk to them. In happy families that information will be shared. In close families, brother and daughter will know that their sister or mother has had tests and a scare. Moral or legal obligations scarcely enter the picture. In estranged families, do *obligations* come into play? I would argue that a family member holding information crucial to the good health of his or her relatives owes an ethical obligation to consider sharing that information.<sup>63</sup> Should the law enforce such an obligation, and if so how? Let us consider the example of "hereditary breast cancer". Two possibilities present themselves. (1) Could a woman dying of breast cancer bring a claim in negligence if for example, her sister

<sup>60</sup> See generally G.T. Laurie, *Genetic Privacy: A Challenge to Medico-Legal Norms* (Cambridge 2002), especially at pp. 104–113.

<sup>61</sup> See Human Genetics Commission, *Inside Information: Balancing interests in the use of personal genetic data* (May 2002); D. Bell and B. Bennett, "Genetic Secrets and the Family" (2001) 9 *Medical Law Review* 130; L. Skene, "Genetic Secrets and the Family: A Response to Bell and Bennett" (2001) 9 *Medical Law Review* 162; R. Gilbar, "Medical Confidentiality Within the Family" (2004) 18 *International Journal of Law, Policy and the Family* 195.

<sup>62</sup> See O'Neill, "Some Limits of Informed Consent", note 18 above. And see Human Genetics Commission, note 61 above, para. [4.1].

<sup>63</sup> But note that it cannot be shown to be unequivocally beneficial to inform the "at risk" relative especially if there is no action the latter can then take to minimise the risk that the disease materialises: G. T. Laurie, *op. cit.*, 264–274 and 239–40.

failed to disclose that she had tested positive for BRCA 1<sup>64</sup> when she was aware that the claimant too was at risk of a hereditary form of breast cancer and thus deprived her sister of the chance to opt for a prophylactic mastectomy? Is the genetic relationship sufficient to create a duty to disclose? (2) Is a health professional entitled to breach her patient's confidentiality to protect the at risk sibling, or indeed liable for failing to do so?

Some consideration has been given to the potential liability of the health professional who fails to warn family members at risk of genetic disease.<sup>65</sup> The professional finds herself on the horns of a dreadful dilemma. Should she disclose information obtained in confidence from sister A to sister B, she risks a claim for breach of confidence from A. Should she fail to warn B, B may attempt a claim in negligence. The professional will be advised by her professional codes of practice to make every effort to persuade A to share information with B. If A adamantly refuses to do so, the responsibility for that decision is primarily her responsibility. Could her silence result in legal liability if that silence results in harm in that her sister develops a cancer at a stage when the prospects for cure are poor?

Such a deceptively simple question conceals the problems of clothing simple moral duties in legal robes. One argument should not assist the silent sister. No claim to privacy excludes responsibility to her relatives. Article 8 (1) speaks of "respect for private and family life". The individual and the family are linked. Article 8 (2) requires that claims to privacy be balanced with the interests of others, notably interests in health. Ngwenya and Chadwick<sup>66</sup> highlight how if we concede an *absolute* right of silence to sister A, we not only ignore the welfare of the "at risk" sister B, but we also compromise her autonomy. B is deprived of information pertinent to her capacity to make autonomous decisions about her health and her body.

A has no right to remain silent but establishing a duty to disclose is more problematic. The court will be asked to rule that genetic relationship is of itself sufficient to create a special

<sup>64</sup> This gene is responsible for 5–10% of breast cancers. Female gene carriers are at an 80–85% risk of developing breast cancer and a 50–60% risk of developing ovarian cancer. The cancers are highly aggressive. If one sister is found to carry the gene, an identical twin sister would also carry the gene; other sisters would be at 50% risk of carrying the gene, and maternal cousins at 25% risk.

<sup>65</sup> G.T. Laurie, note 60 above, 267–272. And see G. Laurie, "Obligations Arising from Genetic Information, Negligence and the Protection of Familial Interests" (1999) 11 C.F.L.Q. 109; K. Offit *et al.*, "The 'Duty to Warn' a Patient's Family Members About Hereditary Disease Risks" (2004) 292 J.A.M.A. 1469.

<sup>66</sup> C. Ngwenya and R. Chadwick, "Genetic Diagnostic Information and the Duty of Confidentiality: Ethics and the Law" (1993) 1 Medical Law International 73.

relationship necessary to impose a positive duty to act.<sup>67</sup> In assessing whether imposition of such a duty is “fair, just and reasonable”<sup>68</sup> the judges will take account of the consequences and practicability of the imposition on a duty of care. What would be the parameters of such a duty? In the context of BRCA 1 might a duty be owed to the identical twin sister who is indubitably at risk, but not to other siblings?<sup>69</sup> What kinds of harm would be within the scope of the duty? In the context of my example, sister B can establish personal injury, the onset of a preventable cancer. Laurie<sup>70</sup> skilfully outlines the many other sorts of claim that might ensue in relation to genetic disease, for example, by a child claiming that she should not have been born, or a partner contending that failure to disclose imposed a disabled child on him or her. How would the requisite standard of reasonable care be addressed? Would the closeness of the family in its social context be a factor? If B had stolen A’s husband, would that be a reasonable excuse to refrain from any contact? What level of effort to disclose would the law demand? Must A actively seek out a sister she has not seen for decades?<sup>71</sup> Would a sister, who reflectively decided not to share the disturbing information with a cousin at low risk whom she knew might become suicidal if warned, paradoxically discharge her duty of care by remaining silent? The practical problems are formidable. The heart of the principled question remains what generates the responsibility to protect the “at risk” sister? The information that led A to seek testing is likely to be equally available to B.<sup>72</sup> If a duty is found, it rests on familial relationships alone—it would indeed declare us to be our brothers’ keepers.

What of the professional’s responsibilities? Confidentiality in English law, unlike the claim to bodily integrity, is already a *relative* obligation. Public interest defences considered in the courts so far, tend to centre on more dramatic instances of possible harm, such as the risk of a psychopath going on another shooting spree,<sup>73</sup>

<sup>67</sup> See Markesenis, note 34 above.

<sup>68</sup> See *Caparo Industries plc v. Dickman* [1990] 2 A.C. 605, 617–18. And see note 33 above.

<sup>69</sup> Or to cousins on the maternal line, or even brothers. Men can get breast cancer. It becomes a question of foreseeability of risk. The female cousin will be at 25% risk, the brother at 50% risk of carrying the gene, but much less likely to develop cancer in residual male breast tissue.

<sup>70</sup> See note 65 above in “Obligations Arising from Genetic Information Negligence and the Protection of Familial Interests”, 117–20.

<sup>71</sup> Or take steps to try to trace a sibling (or even a child) given up for adoption.

<sup>72</sup> And should a claimant successfully overcoming the formidable obstacles of establishing a duty of care and proving breach would she fall at the final hurdle of causation? Disclosure of the risk of cancer by her sister does no more than reduce the risk of the claimant will avoid the disease. She would have to prove that she would have acted on that information to reduce her risk; see *Chester v. Afshar* [2005] 1 A.C. 139. And then she will have to establish that her “lost chance” to avert the relevant injury rendered it more likely than not she had been informed of the risk, she would have avoided injury; see *Gregg v. Scott* [2005] UKHL 2, [2005] 2 A.C. 176, H.L.

<sup>73</sup> *W. v. Egdell* [1990] Ch. 359, C.A.



the spectre of the doctor spreading HIV.<sup>74</sup> The potentially devastating impact of certain kinds of genetic disease and the possibility of preventing other family members from suffering the worst effects of such disease would seem to justify non-consensual disclosure in exceptional cases.<sup>75</sup> But such cases should be truly exceptional.<sup>76</sup> Imposing a duty to disclose and potential liability in tort to “at risk” relatives could be counter-productive.<sup>77</sup> More importantly, in the context of this paper, liability compelling professionals to disclose genetic information locates the fundamental responsibility to warn of genetic risk in the wrong person. In the USA, where a number of duty-to-warn cases have been litigated<sup>78</sup>, the preponderance of judicial opinion<sup>79</sup> has been that any duty to the patient’s relative is discharged by advising the patient that *she* should inform her relative of the risk she shares with them.<sup>80</sup> If it is *my* relatives who are of risk because of *our* heritage, the responsibility to act to protect those family members is primarily mine. Professionals can and should inform and advise me to assist me to discharge my ethical responsibilities. I cannot shuffle off responsibility to them. They should not be forced to act as moral policemen. My responsibilities may not translate into legal obligations. What identifying my ethical responsibilities may do is identify the limits of the obligation owed to me. My failure to honour my obligations to my family may exceptionally release my doctors from his obligations to me. He is no longer bound to keep my confidences.

## VII. A LIMIT ON RIGHTS—JUSTICE?

Deliberate or reckless transmission of disease is a rare (albeit not unknown) occurrence. Most families share information with each other out of love not duty. Does responsibility for others—a duty to do no harm to others impinge more generally on demands for health care-rights to health care? I want to suggest that it does. I ought not to make demands that have adverse effects on others without first weighing respective interests. Health professionals have no responsibility to concede to demands where the detrimental effects on other people outweigh any benefit to the demanding

<sup>74</sup> *X. v. Y* [1988] 2 All E.R. 648.

<sup>75</sup> See (*inter alia*) Human Genetics Commission, note 61 above, at para. [43]. Nuffield Council on Bioethics, *Genetic Screening: Ethical Issues* (Nuffield Council on Bioethics, 1993), para. [5.29]. G. T. Laurie, note 60 above, at 271–72.

<sup>76</sup> See Mason and Laurie, note 14 above, 224–28.

<sup>77</sup> See G.T. Laurie, note 60 above, 267–274.

<sup>78</sup> *Ibid.*

<sup>79</sup> See *Pate v. Threlkel* 661 So 2d 752 (Fla. 1970).

<sup>80</sup> Though note *Safer v. Estate of Pack* 677 A.2d 1188 (N.J., 1996), discussed in G.T. Laurie, *op. cit.*, 268–9.

patient; benefit being defined to include the value of personal choice. An emphasis on choice within the NHS increasingly results in clamour that patients must be given what they demand. Autonomy is extended to an argument that it creates an obligation on doctors to satisfy that choice. In its crudest form, this is a claim firmly rejected by the Court of Appeal in *R. (on the application of Burke) v. General Medical Council*.<sup>81</sup>

... a patient cannot demand that a doctor administer a treatment which the doctor considers is adverse to his clinical needs.<sup>82</sup>

Autonomy and the right of self-determination do not entitle the patient to insist on receiving a particular medical treatment, regardless of the nature of the treatment. In so far as a doctor has a legal obligation to provide treatment this cannot be founded simply upon the fact that the patient demands it. The source of the duty lies elsewhere.<sup>83</sup>

The professionals' duty of care is not derivative from any demand for treatment. But is *Burke* right?

Let us consider one much-publicised scenario. There has been extensive debate about a woman's right to a Caesarean section on demand. In 2002, AXA-PPP, one of the country's major private health insurers declared it would no longer fund *any* Caesarean sections.<sup>84</sup> The cost was escalating and PPP judged that it was too difficult to distinguish between the lifestyle Caesarean—"too posh to push"—and Caesarean surgery necessary to protect the health of mother and child. It had been estimated 3%–5% of Caesarean sections are now performed on the basis of maternal choice not clinical need.

In 2004 the National Collaborating Centre for Women's and Children's Health issued guidelines for the NHS about Caesarean sections. These guidelines were commissioned and endorsed by the National Institute of Clinical Excellence (NICE).<sup>85</sup> The Guidelines provide that maternal request "is not on its own an indication for CS". Clinicians have a right to decline such requests but the woman's decision should be "respected" and she should be offered referral for a second opinion. Studies cited in the Guidelines indicate a maternal preference rate for Caesarean Section of 6–8%.

Statistics are not the whole story. A woman who has undergone a nightmare labour affecting her relationship with her first baby

<sup>81</sup> [2005] EWCA (Civ) 1003.

<sup>82</sup> para. [35].

<sup>83</sup> para. [31].

<sup>84</sup> Reported in *The Times* 9 November 2002.

<sup>85</sup> *Caesarean Section: National Collaborating Centre for Women's and Children's Health* (RCOG Press, April 2004).

may choose a caesarean for her next delivery even though no physical factors contra-indicate a trial of labour. Her choice is closely related to her health and motivated in part by her sense of responsibility to her coming child. What of the choice ensuing from a desire to time delivery to the minute, or to avoid the pain of childbirth or to avoid the risks of tearing, or stress incontinence? It has been reported that 31% of female obstetricians would choose a surgical delivery for just those reasons.<sup>86</sup> It is not, in itself, an irrational, and certainly not an *immoral* choice. I hold no brief for those who criticised Queen Victoria for trying to minimise the pains of childbirth to escape the curse of Eve. Were there unlimited resources, I would gladly concede Caesareans on demand.

Within the NHS resources are limited. Caesarean surgery is much more costly than normal delivery. Nor is the cost solely financial. If Anne is guaranteed her Caesarean at 12 noon on Monday, Betty may find that surgery which she needs is delayed. The paediatrician whose expertise is most required to assess Cath's sick and premature newborn is unavailable because he is in theatre waiting for Anne's baby. Anne's choice has consequences of which, at the least, she should be made aware. Health professionals must not be obliged to risk harm to other patients to meet one patient's choice.

There will be those who see such an approach as unfair and unjust. It may be argued that denying NHS patients treatment of their choice is unfair because if Anne could pay for her Caesarean she could have it at will. Similarly, is refusing Anne who wants a Caesarean unjust because the common law now concedes that her sister who rejects advice to have a surgical delivery has an absolute right to say no?<sup>87</sup> Even if the foetus's life, or future health is imperilled, the mother cannot be compelled to submit to the knife.

Let us take the charge of unfairness first. The logical consequences of the argument is that whatever is available in the private health market must be available in the NHS. The consequences of an unfettered health market are scary. Patients become consumers purchasing the service of their choice. The very concept of *health care* evaporates. It ceases to matter whether I seek cosmetic surgery to deal with deep-seated insecurities about my large nose, or to enhance my sense of well-being, or simply in the same spirit as I occasionally book a manicure at the local

<sup>86</sup> S. Paterson-Brown, O. Amu, S. Rajendran and I. Bolaji, "Should Doctors Perform an Elective Caesarean Section On Request?" (1998) B.M.J. 462; and see *The Independent* 23 February 2004.

<sup>87</sup> See *Re MB (An Adult: Medical Treatment)* (1997) 8 Med. L. R. 217; *St George's Healthcare NHS Trust v. S* [1999] Fam. 26, C.A.

beauty salon. Doctors become mere service providers.<sup>88</sup> The case that they owe their patient special ethical obligations gradually disappears.<sup>89</sup> Reflect on the decision by AXA-PPP in the private sector to refuse funding for Caesareans. In practice the market will exclude (for all but the fabulously wealthy) uneconomic treatments. What price autonomy for all those women choosing private care believing it offered greater choice in childbirth?

What about the charge of injustice? I can refuse a Caesarean, but you cannot demand one. Control of self, sovereignty over what others may do to you, is qualitatively different from what you may demand others do *for* you. Imagine a colleague drinks too freely one evening. She brushes aside advice to take a taxi back home. You could prevent her risking self-harm and harm to others by removing her car keys or bundling her into your car. Intervening requires you to interfere with her bodily integrity or liberty or both. A high threshold for such coercive intervention is rightly required. You may have got it wrong. Her elated mood is normal; her wine was well watered. Alter the example a little. She asks to borrow your car because taxis are few and far between. No longer is the question whether you are entitled to intervene to violate her liberty to prevent her acting unethically. It is what your own ethical obligations may be. Assisting her to do something potentially harmful to others or herself engages your personal moral responsibilities. You are at least entitled, if not obliged, to say no.

Moreover it must not be forgotten that legal decisions about enforced Caesarean surgery are constrained by the absolute value put on bodily integrity. I cannot be compelled to donate even so much as a drop of blood to save my dying child once born. The pinprick is as much of a battery as major surgery. Caesarean surgery remains major surgery.<sup>90</sup> To construct a legal obligation to submit to such surgery to protect the unborn child while allowing unfettered freedom to refuse a drop of blood to his living sister cannot be logical. An extended Samaritan duty might alter the picture.

<sup>88</sup> See M. Brazier and N. Glover, "Does Medical Law have a Future?" in D. Hayden (ed.), *Laws' Futures* (Oxford 2000).

<sup>89</sup> For much of English history, medicine (such as it was) was provided as a business. The wealthier the client, the more the physician would provide what he demanded at the highest possible cost. This did not mean the rich got better health care, sometimes quite the contrary: see R. Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (London: 1999).

<sup>90</sup> Graphically explained in L. Miller, "Two Patients or One? A Problem of Consent in Obstetrics" (1993) 1 *Medical Law International* 97. And see the emphasis on the implications of Caesarean surgery for women in *Winnipeg Child and Family Services (Northwest Area) v. GDP* [1997] 3 S.C.R. 925 (Canada).

## VIII. DO NO HARM—EVEN TO YOUR DOCTOR?

So far I have tackled fairly easy cases where the conduct or wishes of the “irresponsible” patient will cause tangible harm to others. More complex questions include what do we mean by harm and does an obligation not to do harm extend to the professionals who provide our health care? Both questions are raised in the tragic case of *B. v. An NHS Trust*.<sup>91</sup>

B found herself irreversibly paralysed from the neck down and wholly dependent on a ventilator. After thought and prayer, B concluded that she did not want to continue to survive in such conditions. Psychiatrists ultimately found that she was competent to make a decision about switching off the ventilator. Her doctors refused to do so. They passionately believed that Ms. B could find some remaining quality of life in a spinal rehabilitation unit, and deeply opposed being required to take action which they saw as ending B’s life, as killing B. B went to court for an order that continuing to ventilate her was unlawful. The President of the Family Division, Dame Elizabeth Butler-Sloss, found in her favour. She awarded Ms. B nominal damages for the trespass to her person. She ordered that arrangements be made to comply with Ms. B’s request and switch off the ventilator. The judge did not order the clinicians caring for Ms. B to switch off the ventilator. Nor did Ms. B ask them to do so. B said in her evidence “I fully accept the doctor’s right to say ‘I personally will not do it’”.<sup>92</sup> B was prepared to acknowledge and respect the autonomous choice of her doctors. What she sought and obtained was access to a unit where like-minded clinicians would act on her choice. The crunch question from B’s case, not arising on its particular facts, is this. What if no doctor had come forward prepared to assist Ms. B? On the judge’s reasoning, continuing ventilation without B’s consent was an assault. Must the law compel Dr. X to act against her judgment and conscience to implement Patient Y’s choices?

Does Dr. X have rights of her own to respect for her own ethical values and protection from the harm to her of enforced “wrongdoing”? For wrongdoing is how many doctors might still perceive such conduct. Conscientious objection leads us into murky waters. Paternalism and prejudice have often borrowed its clothes.<sup>93</sup> Suitably contrite “good” girls get abortions; “bad” girls may not, to teach them not to be promiscuous.<sup>94</sup> Such attitudes have nothing

<sup>91</sup> [2002] 2 All E.R. 449.

<sup>92</sup> *Ibid.*, at p. 461.

<sup>93</sup> See in relation to abortion, S. Sheldon, *Beyond Control: Medical Power and Abortion Law* (London 1997).

<sup>94</sup> See I. Kennedy, *The Unmasking of Medicine* (London 1981), 92–3.

to do with conscience. The General Medical Council skirts around the thorny question of conscience. Doctors are (rightly) required to base their treatment advice on clinical judgment of need and not allow their personal views on such matters as lifestyle, culture, beliefs, race, gender or sexuality to prejudice the treatment offered to a patient.<sup>95</sup> The doctor who feels that her own beliefs might affect her advice, must explain her conscientious dilemma to the patient and tell her of her right to see another doctor.<sup>96</sup> The courts will have to confront the question of how to define conscientious objection in much more depth. Hedley J. in *Re Wyatt*<sup>97</sup> speaks of conscience as not “wholly rational”—“more in the nature of intuition or a hunch as to whether something is right or wrong”. Limiting patients’ rights on the basis of a hunch is problematic. Ignoring professionals’ reflective and truly conscientious objections is equally a problem. Society must also explore how far, if at all, health professionals have any claim that their moral and psychological needs should be weighed on any ethical (or legal) scales.

Another kind of end of life dilemma further illustrates this problem. In their 1995 Report *Mental Incapacity*,<sup>98</sup> the Law Commission suggested that an advance refusal of treatment would not extend to a right to refuse certain forms of “basic” care such as washing and changing dressings, or even some kinds of palliative care. Such a restriction is omitted from the Mental Capacity Act 2005. Would such a restriction have been an unjustifiable restriction of autonomy? The purpose of an advance directive is to extend autonomous choices beyond the cessation of a person’s mental competence. An advance directive grants peace of mind in knowing that in old age or disastrous illness, extraordinary, or even some ordinary measures, will not be taken to keep the body alive. So in some respects the advance directive may be seen as promoting current welfare, as much as extending autonomy. A decision to seek to ensure that pneumonia carries one peacefully to the grave if God grants that mercy may be perceived as rational. But, must all choices be respected, rational or irrational? Assume that I detest nurses and the prospect of my stinking body and suppurating ulcers offending their noses and their professional consciences

<sup>95</sup> See General Medical Council *Good Medical Practice*, note 35 above, para. [5]. Note that the GMC is currently consulting in relation to a new draft of *Good Medical Practice* including possible definitions of conscientious objection; see *Ethics Briefings* (2006) 32 *Journal of Medical Ethics* 123–4.

<sup>96</sup> *Ibid.*, para. [6].

<sup>97</sup> *Re Wyatt* [2005] EWHC 2293 (Fam), para. [35].

<sup>98</sup> Law Com. 231, para. [5.34]. And see K. Stern, “Advance Directives” (1994) 2 *Medical Law Review* 57, 66.

offend me not one whit. It is what *I want*. Must “I want” always win?

Overriding refusals of treatment is a topic that medical lawyers and ethicists skirt around. Amend the example of a patient making an advance refusal of routine care to a conscious patient retaining the capacity to make decisions about hygiene. The level of mental capacity required for such a decision is low. An elderly patient, call him Stan, is deeply unhappy to find himself unable to care for himself, sick and in an elderly care ward. His personal habits have always left much to be desired. His rotting teeth infect his body. His determination not to co-operate, leads him to obstruct any attempt to keep him clean. He shares a ward with three other elderly men. None of them is fit to be discharged from hospital. Is the sole question relevant here the disruptive patient’s claim to autonomy and, if so, will the staff be tempted to manipulate the threshold of capacity, as perhaps Kay J. did in *Ex p Brady*? Should society collude in saying that Stan’s bitterness at his plight and his desire for revenge distort his capacity to decide whether or not he be washed? And what about his teeth? If he has always kept well clear of the dentist, suggesting that his current preference to abide by a life long choice is not autonomous is sophistry.

In *ex p. Brady*, the judge referred to *Thor v. Superior Court*<sup>99</sup> where the Supreme Court of California proposed four countervailing interests to a claim for absolute autonomy. They were preserving life, preventing suicide, maintaining the integrity of the medical profession and the protection of innocent third parties. Such a broadside on autonomy raises the hackles. Adoption of the *Thor* principles without reflection cannot be prescribed as a cure. They do aid in a diagnosis. In some contexts, but not others, English courts already weigh the interests of the patient against the needs of third parties. What of preserving life and preventing suicide? What are we really addressing is sanctity of life, a topic on which British society is deeply divided. We fudge the issues. Switching off a ventilator is not an act, at least if a doctor does it.<sup>100</sup> Ms. B is thus “allowed” to die while Mrs. Pretty<sup>101</sup> was precluded from any assistance to die. Those who condemn the decision in *Pretty*, talk of physician assisted suicide eliding the difference between such “assistance” and lawful killing, legalised euthanasia. We use a partial notion of autonomy to avoid uncomfortable moral questions in this context.

<sup>99</sup> (1993) 5 Cal 4th 725.

<sup>100</sup> See *Airedale NHS Trust v. Bland* [1993] A.C. 789, 881–2, per Lord Browne-Wilkinson.

<sup>101</sup> *R. (on the application of Pretty) v. Director of Public Prosecutions* [2002] 1 A.C. 800, H.L.; *Pretty v. United Kingdom* [2002] 2 F.L.R. 45, E.C.H.R.

It is the third *Thor* factor that should detain us the longest. What of maintaining *medical integrity*, that is the profession's claim to maintain its own ethical standards and not simply deliver a service? Could any modern medical lawyer buy that hoary chestnut? No-one who has sought to persuade the courts and policy makers to endorse patients' rights could defend such a dated notion. If I do, ought I to be burned for heresy alongside Daniel Callahan and Onora O'Neill? So be it. For if medical integrity has no ethical value, medical ethics itself becomes irrelevant. If doctors and nurses are mere service providers obliged to deliver what is ordered, whatever their own ethical values and whatever the cost to them, we can chuck Beauchamp and Childress on to the remainder pile. Doctors simply supply the goods. Compensation is available for sub-standard goods. Outrageously bad medical practice will be punished by the criminal law. Doctors who do not want to supply particular goods simply do not. They have no more obligation to explain themselves than the window cleaner who refuses to clean your awkwardly placed window. They no longer have an obligation to care.

#### IX. FREEING THE CAPTIVE HELPER

Draper and Sorrell<sup>102</sup> explore the concept of the doctor as the "captive helper". They highlight how first, individual doctors are currently only permitted to end a professional relationship with a patient in exceptional circumstances and, second, even in circumstances where a doctor is allowed to end his or her particular relationship with a patient "... the profession as a whole will continue to provide care for the patient".<sup>103</sup> Draper and Sorrell offer a number of justifications for medical captivity—which in itself constrains the autonomy of the doctor. The vulnerability of patients and the notion that doctors sign up to captivity on joining the profession are of themselves found insufficient. For Draper and Sorrell, the key factors are (1) the nature of the doctor/patient relationship and (2) the risks of unjustified discrimination against certain kinds of patient.

They argue that the doctor/patient relationship is akin to a family relationship. The doctor provides a bulwark against the hostile environment of illness. So they say forthrightly:<sup>104</sup>

It is generally better for doctors to be—like the friends and relatives—captive helpers because it is an important part of

<sup>102</sup> Note 14 above, at pp. 347–52.

<sup>103</sup> *Ibid.*

<sup>104</sup> *Ibid.*, at pp. 348–9.



doctoring that patients in need are not abandoned, even when some of their patients are undeserving in the sense that they perpetually put themselves in need of care.

They go on to warn further of the risks of releasing doctors from captivity.<sup>105</sup>

doctors might all too readily act on questionable judgments about patients' behaviour if they were free to break off their relationship with patients too easily.

Yet paradoxically, in endorsing medical captivity, Draper and Sorrell find further grounds to demand patient responsibility. Captivity should not be "unconditional and permanent". They struggle though, as I do, to determine what circumstances, if any, justify the doctor releasing herself from captivity. They conclude that outrageous and abusive behaviour may justify an individual doctor refusing to continue to treat a patient. The profession's collective duty endures at least where the irresponsible patient's life or health is at risk. In cases that fall short of life or death "it is not unethical for doctors to free themselves from this captivity".

Draper and Sorrell's analysis of the "captive helper" highlights two important points about patients' responsibilities. First, it emphasises the importance of the integrity of the medical profession. The profession has itself surrendered to the captivity they describe. The obligation to make the care of the patient their first concern and to provide treatment on the basis of *need*, regardless of personal preference, or risk to self, or fundamental disagreements with the patient distinguishes the professional from the business man or woman. The plumber is entitled to choose for whom she will work. The chef can refuse to serve tomato ketchup, or remove inappropriately dressed customers from his restaurant. Their primary concern is allowed to be how much can they charge, what will the market bear? No solicitor has an obligation to act *pro bono*. Such obligations attach to doctors because at present in the United Kingdom a "social contract" binds the medical profession. Second, the concept of the captive helper voluntarily "contracted" into that captivity defines its limits. It does not entail obligations to accede to irresponsible demands, to engage in conduct that the dispassionate observer would regard as unethical. A wholly one-sided approach to medical ethics which reduces the clinician to technician will ultimately undermine the integrity of the profession and render medical ethics otiose.

<sup>105</sup> *Ibid.*, at p. 349.

## X. CONCLUSIONS

English law has been slow to recognise that people's rights do not evaporate when they become patients. Law lagged behind ethical debate. This paper argues that the law should not be equally dilatory in recognising that empowered patients also have moral responsibilities. Identifying when and how those moral responsibilities become legally enforceable remains difficult. Lawyers need to be more ready to enter that debate. A failure to define and endorse appropriate responsibilities may ultimately erode patients' rights. In contexts such as disease transmission, or even genetic risks, authoritarian politicians may look for draconian solutions. Medical practitioners who find themselves subject to what they perceive as unethical demands will consider two options. Some may well embrace the consumer-orientated model of medicine rejoicing in the ensuing profit and freedom. Beneficence will fade away. Others will seek different escape routes from medical captivity radically limiting what they choose to offer their patients.