

## Medical Law

**Topic 1** (of 10): **Consent to Treatment:**

**Lecture 1** (of 4):

### The Nature of Consent and the Potential Criminal Liability for Exceeding Consent

**Aim:**

To focus on the nature of consent; to highlight the role of consent in underpinning the administration of most medical treatment; and to note the potential criminal liability for exceeding consent.

**Objectives:**

After carefully reading the following notes and all other readings prescribed for this lecture, you should be able to:

1. Discuss, in detail, how English law proclaims to enshrine the principle of respect for the autonomy of a patient; and the circumstances and the nature of the liability which might arise for a health-care professional overriding patient autonomy;
2. Evaluate the possibility of a doctor incurring criminal liability for failing to obtain a patient's consent prior to the administration of treatment; and
3. Outline the circumstances under which English law has not permitted, and will not permit, an autonomous person to have the overriding right of self-determination in respect of decision-making relating to the administration of medical treatment.

#### The Law Underpinning the Doctor - Patient Relationship

The physical contact made by a doctor examining, or administering treatment, to a patient, is lawful if consent to the contact is given by an autonomous patient or by a person with authority to make decisions for the patient, e.g., a parent consenting on behalf of his/her young child. Of course, if the information on which the person bases his 'consent' is given negligently or the information on which to base a valid consent is inadequate, then any administration supposedly based on consent may, in fact, attract legal liability. **Consent**, thus, has a **dual purpose**. The *first purpose* is:

- to protect the bodily integrity of an autonomous person (the patient) by attaching civil and/or criminal liability to *unwanted* contact, i.e., contact in the absence of consent where that consent could – and should - have been obtained; or where its refusal was deemed to have been communicated and that includes, for example, refusal of consent being deemed to have been communicated by virtue of information contained in a card belonging to a Jehovah’s Witness proclaiming ‘no blood or blood products’ to be administered, should the occasion arise. That liability may attach to a member of the medical profession who overrides a patient’s wishes was affirmed by **Sir Thomas Bingham MR** in Airedale NHS Trust v Bland [1993] 2 WLR 316 at 334G where he said:

“It is a civil wrong, and may be a crime, to impose medical treatment on a conscious adult of sound mind without his or her consent”: In re F (Mental Patient: Sterilisation) [1990] 2 AC 1.

The second purpose of consent, then, is:

- to provide a defence to a doctor who has physically examined an autonomous patient who had consented to the contact, or a patient for whom the appropriate lawful consent had been given.

In essence, this means that the law relating to physical contact in the doctor-patient relationship is precisely the same as that in any other relationship between human beings, viz; consent to any physical contact that is not against public policy is not unlawful. Accordingly: “There is no special law in this country that places doctors in a separate category and gives them extra protection over the rest of us” per **Farquharson J** in R v Arthur (1981) 12 BMLR 1.

## The Point at Which Liability for Non-Consensual Contact Arises

The general rule is that:

“... *everybody* is protected ... against *any* form of physical molestation. ... [though this rule is] subject to exceptions. For example ... people may be subjected to the lawful exercise of the power of arrest; and reasonable force may be used in self-defence or for the prevention of crime ... [moreover] a broader exception has been created to allow for the exigencies of everyday life. Generally speaking, consent is a defence to [the tort of] battery; and most of the physical contacts of everyday life ... are impliedly consented to by all who move in society and so expose themselves to the risk of bodily contact. So nobody can complain of the jostling which is inevitable from his presence in, for example, a supermarket, or underground station or a busy street; nor can a person who attends a party complain if his hand is seized in friendship, or even if his back is, within reason, slapped ...” (per **Goff LJ**, Collins v. Wilcock (1984)).

Similarly, consent to participation in properly conducted physical contact sports such as boxing, football and ice hockey will negate liability for injuries which reasonably may be expected during the course of the sport in question. However, punching an opponent in (say) an 'off-the-ball' incident in a football match would constitute a battery as it is neither an injury which reasonably could be expected nor is it permissible under public policy for a victim to consent to an act which causes him bodily harm.

It would appear, then, that the law will impose liability for an unwanted touching, i.e. one that is not agreed or assented to, (or deemed to be unlawful), if it is more than *de minimis*<sup>1</sup> and which it regards as against public policy (perhaps because it was performed for no good reason).<sup>2</sup>

### Consent in the Doctor-Patient Relationship

The application of the general rules of consent to the doctor - patient relationship is clarified once the meaning of 'consent to treatment' is explained. With regard to medical treatment, consent means more than mere 'acceptance', 'agreement', or 'assent'. In his book *Philosophical Medical Ethics* (Wiley, 1986), **Gillon** (at p113) says that:

"For medical interventions it is widely accepted that consent means a voluntary, uncoerced decision, made by a sufficiently competent or autonomous person on the basis of adequate information and deliberation, to accept rather than reject some proposed course of action that will affect him or her."

The general rule, then, is that any mature person (i.e. any autonomous individual, including a 'mature minor' [see: lecture 2]) who understands the nature of the proposed treatment can submit by way of giving 'real consent'<sup>3</sup> to any medical procedure. The patient's right of self-determination is reinforced by noting that a doctor has a legal as well as a moral (or ethical) duty to respect a person's **autonomy**. It is respect for a person's autonomy that *morally* underpins the *legal* requirement for consent. That a *legal* requirement for consent is based on the *moral* principle of respect for another person's autonomy is merely a specific example of the general rule that: "... every legal duty is founded on a moral obligation." (per **Coleridge LCJ**, in *R v. Instan* (1893)).

The concept of autonomy<sup>4</sup> is frequently said to consist of: autonomy of thought; autonomy of will; and autonomy of action.

- *Autonomy of thought* includes the ability to 'think for oneself';
- *autonomy of will* is the freedom to decide to do things on the basis of one's own deliberations; and

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<sup>1</sup>For example, the use of more force than is strictly necessary in a claim of self defence.

<sup>2</sup>For example, the sado-masochistic practices in *R v. Brown*, et al (1992). (See *infra*, p7).

<sup>3</sup>The meaning of 'real consent' and how it may differ from 'informed consent' is discussed in Topic 1, Lecture 3.

<sup>4</sup> See Topic 2, Lecture 4 for further analysis of autonomy and its relationship with other ethical principles.

- *autonomy of action* is the ability to exercise one's autonomy of thought and will subject to the respect for the autonomy of others.

### **Right of Self-Determination / Autonomy is Enshrined in Moral Theory and in Law.**

The right of certain individuals to self-determination is a focal point of *Mill's Harm-to-Others theory* which he expressed in his essay *On Liberty*, written in 1854 and published in 1859. Mill was of the view:

“That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. ... The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. ... *Over himself, over his own body and mind, the individual is sovereign.*”

The *common law* affirms an individual's right to bodily integrity by providing for the sanction that the absence of consent will normally constitute a trespass to the person. The classic statement is that of *Cardozo J* in the *American* case of *Schloendorff v Society of New York Hospital* (1914) where he said that:

“Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault ...”<sup>5</sup>

Thus, even the fact that a surgeon was acting, as he thought, in the best interests of a patient (other than in a case of 'necessity'), and an operation was carefully, skilfully and successfully performed, would **not** provide him with a defence if he was sued for battery if he performed the operation without his patient's consent. (**N.B.:** 'Battery' and 'trespass to the person' are frequently used as synonymous terms denoting tortious actions; 'assault' is usually confined to criminal actions or tortious actions not involving physical contact).

That there is no scope for promoting the principle of 'doctor-knows-best' over the express refusal of a patient to consent to treatment was made clear in the *American* case of *Bennan v Parsonnett* (1912) where it was stated that:

“No amount of professional skills can justify the substitution of the will of the surgeon for that of his patient.”

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<sup>5</sup> *Schloendorff* has been cited with approval by the **House of Lords** in *Airedale NHS Trust v. Bland* [1993] 2 WLR 316, 367E-F where *Lord Goff* said: “ ... it is established that the principle of self determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so: see *Schloendorff v. Society of New York Hospital* (1914) 105 N.E. 92, 93, per Cardozo J.”

Similarly, in English law, it has been said that: “In modern law medical paternalism no longer rules ...”, per **Lord Steyn**, *Chester v Afshar* [2005] 1 AC 134 @ para16.

Moreover, this principle applies to ‘life-or-death’ situations. Indeed, it was established in the **Canadian** case of *Malette v. Shulman* (1990) that overriding this principle can lead to an award of damages for *life-saving*, but non-consensual, medical treatment.

### **Malette v Shulman (1990) 72 OR (2d) 417**

Mrs M, a Jehovah’s Witness, was unconscious and bleeding profusely as a result of a road traffic accident. She carried a card requesting that ‘no blood or blood products be administered to me under any circumstances’. Nevertheless, soon after arrival at the hospital the doctor in the emergency department decided that her condition was serious and she needed a transfusion.

**Held:** Despite the doctor’s good motives and his thinking that he was acting in her best interests, the intervention constituted a battery and M was awarded damages of \$20,000.

{That the law will not sanction the administration of treatment to a competent patient who refuses it is because: ‘For our law to *compel* [a patient] to submit to an intrusion of his body would change every concept and principle upon which our society is founded.’ (per **Flaherty J** in the **American** case of *McFall v Shimp* (1978)).

Indeed:

“No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from the restraint of interference of others, unless by clear and unquestionable authority of law”.

(*Dictum* in the **American** case of: *In the Matter of Claire Conroy* (1985))}

## **Summary of the Nature of Consent**

1. The general rule that no treatment is administered to a patient without first obtaining his consent is (a) to provide that patient with legal protection from unwanted bodily contact; and/or (b) to provide an accused party with a defence.
2. Not every act can be consented to, however: in particular, an individual cannot consent to acts which cause him bodily harm and which are against public policy. Accordingly, an individual may not consent to the administration of a lethal dose of medication even though he may be suffering from a terminal illness and be in excruciating pain: *Dr Cox’s case* (1992) [see notes on Euthanasia in Topic 10].
3. Consent has both a moral aspect (principally by virtue of the principle of respect for autonomy) and a legal aspect; and that consent underlies the whole of medical practice there is no doubt - especially since there is no separate category of ‘medical touchings’.

## Appendix: Overview of the potential legal liability for non-consensual contact and the circumstances under which it may arise

### Background.

Legal action in respect of non-consensual medical treatment may result in criminal charges (relatively rare) or, more likely, civil (tortious) action. As noted *supra* (p2), in *Airedale NHS Trust v Bland*, [1993] 2 WLR 316 at 334G, **Sir Thomas Bingham MR** said:

“It is a civil wrong, and may be a crime, to impose medical treatment on a conscious adult of sound mind without his or her consent: *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1.”

That the treatment is life-saving will not, of itself, enable a tortfeasor to escape liability: (see) *Malette v. Shulman* (1990) (*supra*).

A potential defendant, such as a registered medical practitioner (a ‘doctor’), may avoid any criminal liability or tortious liability for trespass to the person if he obtains a *legally valid* consent from his patient. The patient may give valid consent orally, in writing or by means of non-verbal communication, as, for example, by way of holding out her arm to signify consent to being vaccinated as did Ms O’Brien in *O’Brien v. Cunard SS Co.* (1891). Some commentators (e.g., **Kennedy & Grubb**) refer to instances of a patient’s non-verbal communication as giving rise to implied consent. (A temporarily incapacitated patient may be treated on the basis of ‘necessity’ – which is **not** the same as implied consent: see lecture 4 on the lawful administration of non-consensual medical treatment).

### Valid consent is consent given by an autonomous person

An essential pre-requisite of real, or valid, consent is *capacity*. *Capacity is the legal recognition of the moral principle of autonomy* and, as **Skegg** notes: The question of capacity to give a legally effective consent has two aspects: first, whether *anyone* may give a legally effective consent, ... [ i.e., the issue of ‘general capacity’]; and secondly, whether *the person in question* can give a ‘legally effective consent’ i.e. the issue of individual capacity [for which, see Lecture 2]. Two simple examples illustrate these aspects:

(i) no one has the capacity to consent to his own intentional killing by another person; e.g. a patient cannot absolve a doctor from legal liability for ‘mercy killing’. As English law does not recognise mercy killing (i.e., neither ‘active euthanasia’ nor physician (doctor) - assisted suicide) then a doctor who deliberately accelerates the death of one of his patients may be charged with - and convicted of - murder. (See Dr Cox’s case in Euthanasia, Topic 10).

(ii) The success of organ transplantation from living donors illustrates not only the social acceptability of this form of medical treatment, but also that the law recognises, as a general rule, that autonomous individuals have the right, or capacity, to undergo medical interventions that have no value in improving their own physical health i.e. they have the

capacity to undergo 'non-therapeutic' operations. However, whether (say) a particular 14 year old boy would be regarded as having the capacity to donate a kidney, and to override the objections of (say) his parents is, at least, debatable [See Lecture 2: determination of capacity].

So, whereas from point (i) it is clear that a patient does not have the legal authority to consent to his own intentional *killing* by another person, a question arises from point (ii) which is:

### **Does a Patient Have Capacity to Consent to *Bodily Harm*?**

Whereas consent *per se* may negate liability for *some* bodily harm, - donating organs, for example, - an issue of particular relevance is whether some medical treatment which is provided in good faith and administered for the benefit of bodily health can be regarded as causing bodily harm; or is it inappropriate to think of a doctor acting in a 'harmful' or 'offensive' way? This issue arises because there is no identified special category of 'medical touching' as distinguished from other bodily touching [but see p8].

In *R v Donovan* (1934) 'bodily harm' was said to include 'any hurt or injury calculated to interfere with ... health or comfort' and to do so in a manner which is 'more than merely transient and trifling'. *Donovan* was not a case on medical treatment and, *prima facie*, the description would not appear to apply to therapeutic medical procedures, especially as 'benefit' is the converse of harm. Indeed (at p113), in *R v Hyam* (1975) **Lord Hailsham** said: "it is the absence of intention to kill, or cause grievous bodily harm which absolves the heart surgeon in the case of the transplant ..." [Contrast, for example, the intention to kill which equates euthanasia with murder].

However, as **Skegg** observes, 'there may be a small category of procedures which benefit the patient's health, yet do involve bodily harm. These are procedures which could be regarded as involving physical detriment, but where such detriment is thought to be outweighed by psychological benefit. Examples include some 'sex change' operations. Whether such procedures amount to bodily harm could depend on whether 'bodily harm' is taken to include psychological harm which does not have any apparent physical effects. In *R v Miller* (1954) **Lynskey J** said that an injury to a person's 'state of mind for the time being' now comes within the definition of actual bodily harm. ... [so] if it is accepted that bodily harm includes purely psychological harm as well as physical harm, it could be argued that a medical procedure should *not* be regarded as causing bodily harm if physical detriment is outweighed by psychological benefit.

On the other hand, and with particular reference to Jehovah's Witnesses, the psychological detriment suffered as a result of a blood transfusion may well outweigh any perceived physical benefits and lead to a successful claim for damages: *Malette v Shulman* (1990).

Case law has illustrated that it is far more likely that *tortious* liability, rather than criminal liability, will be imposed for the administration of non-consensual medical treatment.

However, it's criminal liability (other than homicide) that is outlined below with tortious liability being discussed in detail in lecture 3.

## **Criminal liability which may be incurred in the administration of non-consensual medical treatment**

If a crime results from non-consensual medical treatment, the potential causes of action are likely to be for: battery; or grievous bodily harm; or maim – though, exceptionally, charges of murder and manslaughter have been brought as illustrated by the cases of Drs Adams, Cox, and Shipman.

However, the rarity of a criminal charge against a doctor in respect of an act on a “consenting patient [that] ..would be a very serious crime if done by someone else [is because] bodily invasions in the course of proper medical treatment stand completely outside the criminal law. The reason why the consent of the patient is so important is not that it furnishes a defence in itself, but because it is usually essential to the propriety of medical treatment”. Per **Lord Mustill** in Airedale NHS Trust v Bland [1993] AC 789.

**Lord Mustill** returned to the issue of consent *per se* being an insufficient defence to a criminal act in R v Brown [1994] 1 AC 212 where he said:

“Many of the acts done by surgeons would be very serious crimes if done by anyone else, and yet the surgeons incur no liability. Actual consent, or the substitute for consent deemed by the law to exist where an emergency creates a need for action, is an essential element to this immunity; but it cannot be a direct explanation for it, since much of the bodily invasion involved in surgery lies well above any point at which consent could even arguably be regarded as furnishing a defence. Why is this so? The answer must in my opinion be that proper medical treatment, for which actual or deemed consent is a prerequisite, is in a category of its own”.

### **(i) Crime of Battery.**

A medical procedure could come within the scope of the crime of battery (sometimes referred to as an assault) provided it involved a bodily touching and it was carried out without a legally effective consent being obtained. This applies equally to therapeutic and non-therapeutic medical procedures. However, a doctor can avail himself of a statutory defence (e.g. as found in the Mental Health Act 1983 (See Lecture 4)) or a common law defence such as necessity.

#### **Conduct that renders consent ineffective and constitutes the crime of battery**

**Skegg** is of the opinion that the likely starting point is the A-G's Reference (No.6 of 1980) [1981] Q.B.715. Here the Court of Appeal started with the proposition that: ‘ordinarily an

act consented to will not constitute an assault.’ However, the Court had to determine ‘at what point does the public interest require the Court to hold otherwise?’ The answer given was ‘*that it is not in the public interest that people should try to cause, or should cause, each other actual bodily harm for no good reason.*’ In such cases, consent would be ineffective in preventing liability being incurred.

The significance of the phrase ‘for no good reason’ was evident when the *Court of Appeal* said: ‘Nothing which we have said is intended to cast doubt upon the accepted legality of properly conducted ... reasonable surgical interference ... th[is] apparent exception can be justified as ... needed in the *public interest.*’

### **Actions attempted for a good reason but which end in failure may not constitute a battery**

Where a medical procedure was intended to benefit a patient but it has in fact failed and caused bodily harm, then, even if it was surgery which could be described as including ‘hurt or injury calculated to interfere with health or comfort’ in a manner which is ‘more than merely transient and trifling’, it would still remain conduct aimed at benefiting bodily health. There would be a good reason for it (it would be in the public interest as well as the individual’s interest) and the power to give legally effective consent is beyond dispute. Thus a failed operation with disastrous consequences does not of itself lead to a *criminal* action.

### **Consent to procedures having no physical benefit may still negate criminal liability**

Sterilisation and the removal of a kidney from a healthy person for the purpose of transplantation into someone, who, as a general rule, is genetically related and is in need of it, provide, perhaps, two examples of medical procedures *not* intended to provide a *physical* benefit to the person on whom they were performed. In the sterilisation case of *Bravery v. Bravery* (1954), for example, the operation was solely intended to prevent the transmission of a hereditary disease. Nevertheless, consent will negate criminal liability.

## **(ii) Crime of Causing Grievous Bodily Harm**

This is a very rare occurrence. In essence, *s.18 OAP Act 1861* provides that it is an offence ‘unlawfully and ... with intent to ... do some ... gbh to any person’. Two principal points arise from this definition:

- i. even if a medical procedure does cause gbh. (a synonym for really serious bodily *harm*: *DPP v Smith* (1961)) a registered medical practitioner (or ‘rmp’ or ‘doctor’) would not be guilty of the offence if he did not intend to cause such harm; (absence of mens rea) and
- ii. the fact that the conduct specified must be carried out unlawfully if criminal liability is to attach to the r.m.p. has led to an interpretation of ‘unlawfully’ as meaning ‘without lawful excuse’: (*R v. Hogan* (1973)) which implies that in certain circumstances a medical procedure which intentionally causes gbh. (removal of a kidney from a healthy donor for transplantation to a needy recipient, perhaps) is not unlawful, i.e. it is a

procedure to which consent may lawfully be given. (In the case of a kidney donation this must comply with the requirements of the **Human Tissue Act 2004** (see Topic 9).

### **(iii) Crime of Maim**

This is an ancient common law offence that has not been expressly abolished. It is based on the distinction between acts which permanently disable and weaken a man, rendering him less able in fighting and acts which simply disfigure. (**N.B.:** At common law, maim applied to men only; not women). Maim has been said to include the disabling or weakening of an arm or foot; or the deprivation of an eye, foretooth or 'those parts, the loss of which in all animals abates their courage' which, presumably, refers to castration. The loss of an ear or nose was not considered to impair a man's capacity to fight and, consequently, was not regarded as a maim.

As the vast majority of medical procedures do not result in permanent disabilities, the scope for the offence of maim is very limited. Even where an amputation of a limb results it is likely that it was a disease that rendered the patient disabled: consequently the subsequent operation falls outside the scope of maim. And as **Skegg** notes: 'even if castration could still be regarded as coming within the potential scope of maim, it would be justified if performed for a therapeutic purpose': Corbett v Corbett (1971) - the 'sex change' case. (See also: Marshall v Curry (1933) infra).

### **References**

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## Workshop Questions, Workshop No. 1

{First, be prepared to answer some short-answer questions where you will be asked to quote some significant judicial dicta from cases noted on pp2-5, supra}. Then:

1. Discuss the scope and content of the moral principle that is at the basis of a patient's valid consent to treatment. What legal recognition, if any, is given to this principle?
2. To what extent, if at all, do you agree with the assertion that: "bodily invasions in the course of proper medical treatment stand completely outside the criminal law"? (Quotation extracted from *Airedale NHS v Bland* [1993] AC 789, per **Lord Mustill**)
3. When, if ever, might criminal liability arise from the administration of medical treatment? When, if ever, might a doctor be charged with murdering one of his patients?

### Question to research:

4. ***Drs Adams, Cox*** and ***Shipman*** were each charged with murder of one or more of their patients. Discuss the circumstances that led to the charges and explain the reasons that led to the different decisions in each case.