Therapy, Battery and Informed Consent

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In its present state the law has little to contribute towards the solution of the problems arising from the medical treatment of mentally incapable, but informal patients. This is because there are no relevant rules; there is no legislation governing the situation because Parliament has not acted; and there are no Common (i.e. judge-made) Law rules because these problems have never come before a judge for decision.

It is not unusual for the medical profession, when faced with a difficult ethical problem, to turn to the law for help, only to be disappointed, (but, perhaps, covertly relieved). It happened about 20 years ago in the case of a brain-death and, more recently, over *in vitro* fertilisation. The former has completed the circuit back to the medical profession with no legal involvement; the latter is more than half-way home though there is a possibility of legislation later, probably confined to embryo research.

When lawyers are asked to advise in situations like these, they have to extrapolate from such rules as are available. This means, in plain language, trying to predict the responses of the judges if and when confronted with the problem for decision. This is at least as unreliable as other forms of extrapolation.

Two methods are used. One is to search for a reported case which has sufficient factors in common with the problem under consideration to provide a useful analogy; the other is to analyse a larger group of judgments in cases which appear to have a common factor or factors, in order to discern, if possible, an underlying 'principle' which can be applied to the new problem. This is, of course, a process of induction and as such, subject to error.

The first method is no use because there is no relevant analogy in the law reports. The second has yielded a 'principle' but its validity is open to question.

Lawyers are romantics at heart and proud of the old Common Law, and so prone to making sweeping generalisations about it which, on examination, turn out to have a surprisingly high emotive content. One runs like this:
"the fundamental principle, plain and incontestable, is that every person's body is inviolate. It has long been established that any touching of another person, however slight, may amount to a battery".[1] The trouble is that it has never been so established because in practice the Courts have never acted on such an extreme view. This so-called principle requires immediate and extensive qualification to reconcile it with the facts of life, e.g. by introducing the concepts of consent, self-defence, necessity, justification (e.g. corporal punishment) etc. etc. Consent has to be extended to implied consent to cover the doctor who operates on an unconscious patient, or the person who bumps accidentally into another in a crowded street.

In fact, the same judge in the same judgment said later that this principle was subject to a general exception "embracing all physical contact which is generally acceptable in the ordinary conduct of daily life". This does not leave much of the principle standing. In truth, the original statement contains more rhetoric than logic. More recently the Court of Appeal has, at last, explicitly stated what has always been implicit, namely, that a battery involves physical contact with an aggressive or hostile intent.[2] This makes sense. A non-aggressive battery is, in ordinary language, a contradiction in terms.

It follows that the law of battery will not provide a valid model for a code of practice for the treatment of mentally incapable patients.

Generations of doctors, however, have been brought up to recognise the importance of consent in the doctor/patient relationship, partly because of a vague fear of 'the law' but much more because of its prominence in medical ethics. There has been for many years in medical, and some legal circles, an impression that therapeutic physical contacts with patients are saved from being regarded in law as trespasses or 'batteries', only by the consent of the patient, actual, presumed or implicit.

This is and always has been an erroneous impression[3] and judges have always rejected attempts to sue doctors for damages for trespass. However, the coming into use in medical writings of the phrase 'informed consent', coupled with transatlantic influences, has stimulated renewed attempts to find a way of recovering damages without having to discharge the burden of proving negligence. They too have been unsuccessful.

'Informed consent' is not a legal concept at all; it is an expression of medical ethics, now in frequent use but without definition. It seems to have originated in the English version of the Declaration of Helsinki promulgated in 1964, by the World Medical Association, to control experiments on human volunteers. The Declaration is not directed to the doctor-patient relationship at all, and expressly recognises that in *clinical* research on patients it may not be appropriate. Nevertheless, attempts have been made to argue that only 'informed consent' could provide a defence for a doctor to an action for trespass or battery.

In Sidaway v Bethlem Royal Hospital[4] in 1985 the House of Lords finally and authoritatively rejected this argument on two grounds, first, the action in trespass does not lie against doctors—negligence or breach of duty must be proved—second, informed consent is not a legal concept.

In some states of the United States, a different argument has succeded. Basing themselves on the written Constitution which, it is claimed, gives every individual the right to control his or her own body, patients' lawyers have argued

https://doi.org/10.1192/pb.11.6.185 Published online by Cambridge University Press

that consent to treatment is a constitutional requirement and effective consent means fully informed consent.[5] Other States have rejected this argument and some have had to legislate against it.

An alternative argument, which is more attractive, is that a doctor owes a duty to give skilled advice to his patient which may include specific warnings about the risks involved in a proposed treatment. This is accepted here and in Canada[6] but there is a difference as to how the extent of this duty in the individual case is to be determined. By a majority of three to two in Sidaway's case the House of Lords held that the Court must act on the evidence of responsible and experienced medical practitioners. The minority, in agreement with the Supreme Court of Canada, thought that the Court should have the last word. But the difference is largely a matter of *amour propre* because in practice the judge would always be dependent on medical advice and could not properly disregard it.

This development of the law may indirectly throw some light on the problem of treating the mentally incapable (whatever that word may mean). Having eliminated battery and with it the more complex and subtle considerations of consent, it seems likely that the Courts will approach the treatment of the mentally incapable by asking how do responsible and experienced psychiatrists consider the patient should be treated, taking into account all relevant matters? If there are differences of view between the experts, it should be enough for the psychiatrist to show that he acted in accordance with the views accepted and acted upon by other experienced and responsible psychiatrists. This is the Bolam principle[7] which has been repeatedly approved by the House of Lords.[8]

This comes close to the general exception in the law of battery, quoted above: "all physical contact which is generally acceptable in the ordinary conduct of daily life (is not a battery)", bearing in mind that no one who has not had experience of mentally ill people can make, unaided, a sound judgement about what is or is not acceptable in this context.

References

[1]Goff, L. J. in Collins and Willcock (1984) 1. *Weekly Law Reports*, 1172.

[2]Wilson v Pringle (1986) 2. *All England Reports*, 440.

[3]Blackstone, W. *Commentaries on the Laws of England.* (1775) vol. 3, p. 122; and Lord Diplock in Sidaway v Bethlem Royal Hospital (1985) *Appeal Cases*, 871.

[4](1985) *Appeal cases*, 871.

[5]Canterbury v Spence (1972) 464 Federal 2nd. 772 US Appellate District Court.

[6]Riebl v Hughes (1980) 114. *Dominion Law Reports*, 3rd 1 Canadian Supreme Court.

[7]Bolam v Friern Hospital Management Committee (1937) 1, *Weekly Law Reports*, 582.

[8]e.g. Sidaway v Bethlem Royal Hospital (Supra) and Maynard v West Midlands Regional Health Authority (1985) 1, *Weekly Law Reports*, 635.

Mental Health Act 1983

Memorandum on Parts I to VI, VIII and X

An updated, amended version of the Explanatory Memorandum to the Mental Health Act 1983 has been published recently. There are no significant policy changes but the main changes that this revised Memorandum introduces are:

(i) It is no longer necessary to advise the Department of Health and Social Security or the Welsh Office of offences under Section 128 of the Mental Health Act 1959 (paragraphs 297 and 298 of the Memorandum)

(ii) New procedures are introduced for Home Office statistical purposes with regard to patients admitted under Section 37 and 37/41 of the 1983 Act (paragraph 167 of the Memorandum).

(iii) Further guidance is given on procedures for the transfer of patients between England and Wales and Scotland and England and Wales and Northern Ireland (paragraphs 236 to 247 and appendix 5 of the Memorandum).

The Memorandum is now a priced, copyright document and further copies are available from local branches of Her Majesty's Stationery Office, price £4.95 each.

St George's Hospital Medical School are holding a course for a **Diploma in Human Sexuality** commencing October 1987. The two-year multi-disciplinary course will offer an opportunity for the acquisition of skills in the treatment of sexual problems and will include a one year day release course and a second year of supervision of cases in trainee's own work setting. Full details: Miss B. A. Charman, Postgraduate Office, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE.

The American Society of Law and Medicine is planning its **Second International Conference on Health Law and Ethics** for 17–22 July 1988 at the Queen Elizabeth II Centre, London (opposite the Houses of Parliament). Further details: Larry Gostin, Executive Director, American Society of Law and Medicine, 16th Floor, Boston University School of Law Tower, 765 Commonwealth Avenue, Boston, MA 02215, USA.