

Disclosure of Confidential Information to Protect the Patient: The Role of Legal Capacity in the Evolution of Professional Guidance

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Abstract

There are a number of exceptions to the general rule that patients at risk of harm because they withhold consent to doctors disclosing their confidential information should be respected. Disclosure may be mandated by law or the patient may lack capacity under the Mental Capacity Act 2005. Beyond this, the law is vague and professional guidelines differ in approach. The public interest defence operates to protect third parties. The General Medical Council's 2009 guidance on confidentiality accepts that it might also apply to prevent harm to the patient. This article argues that to do so could be contrary to legislative intent and has potential to contravene the patient's human rights. The article proposes that decisions taken in the best interests of patients should be limited to those situations in which patients lack capacity to consent. It explores the recently extended ambit of the test for capacity at common law which may facilitate a clearer approach to disclosure decisions which will improve compliance with the liberal ethos of the Mental Capacity Act and aid conceptual consistency.

Introduction

Uncertainties as to the conceptual boundaries of the duty of confidentiality are reflected in its practical application and variations in the advice offered in professional guidance. This article looks at the evolution of the law and guidance with respect to patients who withhold their consent to disclosure of their medical information to third parties in situations where non-disclosure will cause them serious harm. It argues for a clearer separation of the best interests and public interest defences to disclosure of confidential information.

Consent is the primary justification for disclosure, but other defences exist. In some cases the law *mandates* disclosure. For example, the police may obtain a court order for the disclosure of confidential information under Schedule 1 to the Police and Criminal Evidence Act 1984 and doctors may be required to

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report certain infectious diseases. In these cases a failure to disclose confidential information may indeed cause the patient harm, but the overriding concerns are the societal interests in preventing physical harm to others and the justice concerns surrounding the securing of relevant prosecutions. The law also *allows* disclosure in some circumstances, either because it is in the public interest or because the patient lacks legal capacity and disclosure is in their best interests.

Disclosure of confidential information must be justified. In *Z v. Finland* the European Court of Human Rights said:

‘Respecting the confidentiality of health data is a vital principle in the legal systems of all the Contracting Parties to the Convention. It is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general.’¹

This suggests two goals: protection of privacy and protection of the public health. The defences to breach of confidentiality must be considered in light of the Human Rights Act 1998 which has resulted in a refined interpretation of the necessary balancing exercise to be undertaken. Article 8(1) of the European Convention on Human Rights protects the right to a private and family life. Article 8(2) provides the exceptions where interference is:

‘... in accordance with the law and is necessary in a democratic society in the interests of ... public safety..., for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedom of others.’

Disclosure to protect the patient, it seems, might fall within the Article 8(2) exceptions, provided it is ‘necessary in a democratic society’. In *Z v. Finland* it was said:

‘The court will consider whether, in the light of the case as a whole, the reasons adduced to justify them were relevant and sufficient and whether the measures were proportionate to the legitimate aims pursued.’²

Proportionality must be assessed in light of the aims of the tort of confidentiality, which upholds private and public interests in keeping information secret and protecting the public health. This can be contrasted with the tort of battery where there is greater emphasis on protection of private interests. We should not necessarily expect equivalence in the role of consent in the two torts: consent arguably plays a stronger role as a defence to unwanted bodily invasion than it does as a defence to unwanted disclosure of information. In both cases, however, there are circumstances in which the law will disregard the patient’s views in order to serve the public interest. Consent is a primary defence to disclosure and the patient’s interest in controlling private information is strong. Disclosure may be considered proportionate and necessary where consent cannot be sought

¹ *Z v. Finland* [1997] 25 EHRR 371, para. 95.

² *Ibid.*, [94].

(e.g. due to a lack of practicability). It is considerably more difficult to justify disclosure when a patient's consent has been sought and refused.

Disclosures to protect others

Disclosure against the wishes of a patient may be justified in order to protect the interests of others. Consider laws governing the protection of community safety. A health authority *can* share information under the Criminal Justice and Court Service Act 2000 provided there is a risk of serious harm to the public. And section 19 of the Police and Justice Act 2006 allows disclosure of personal information where identification of an individual is necessary to allow the crime and disorder committee to exercise its powers. Healthcare professionals might also share information under section 115 of the Crime and Disorder Act 1998, but only in compliance with human rights, the Data Protection Act 1998 and the common law duty of confidentiality. Under section 17A, mandated disclosure is sometimes appropriate, but only in de-personalised form. The restrictive approach taken by the law will surprise some. After all, society has an interest in detecting, preventing and prosecuting crimes. But it also has an interest in protecting confidences.

Laws also exist to protect the public health. Some, like mandated reporting of infectious diseases, exist to protect society from tangible health risks. Others flow from a societal interest in combating unethical and/or illegal practices. For example, England is considering mandated reporting by doctors and social workers of female genital mutilation (FGM) – an unlawful activity³ – and child abuse.⁴ The common law might also be invoked to protect the public interest. The public interest defence to breach of confidentiality recognises that disclosures can be made where the public interest in maintaining the confidences of the patient are trumped by the public interest in disclosing the information to others.⁵ Thus, there is a public interest both in revealing certain information and in keeping information secret. It can operate to defend the doctor who

³ Female Genital Mutilation Act 2003.

⁴ FGM: House of Commons Home Affairs Committee, *Female Genital Mutilation: The Case for a National Action Plan*, (July 2014) proposes making the failure to report child abuse a criminal offence if other measures to increase the level of reporting are not effective in the next 12 months. See www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/201/20102.htm (accessed 1 March 2015). Child abuse: The Children Act 2004, s 11 places a duty on NHS Trusts (and others) to make arrangements to ensure that 'their functions are discharged having regard to the need to safeguard and promote the welfare of children'. At the time of writing, a proposed new 'victims law' could mandate reporting in some circumstances. T. Ross, 'Chris Grayling Unveils New "Victims Law"', *The Telegraph* (14 September 2014).

⁵ *W v. Egdell* [1989] *EWCA Civ* 13.

discloses information about a patient to protect a third party from serious harm, or to prevent a serious crime.⁶

Disclosures to protect the patient

Where the harm caused by a failure to disclose confidential information will result only to the patient, an alternative defence – the best interests defence – may be available, but this is limited in law to those situations where the patient is unable to consent due to a lack of capacity. The Mental Capacity Act 2005 operates a presumption of capacity.⁷ Where the presumption is rebutted, the best interests test applies; the patient's views being one of a number of relevant factors.⁸ As we shall see, the laws on capacity have a long and complicated history and are far from settled.

If the patient has capacity, can the public interest defence be used instead? To do so risks conceptual conflict with the law's recognition that people with capacity have a right to make autonomous decisions. This position is central to the Mental Capacity Act and has long been protected at common law. It was famously articulated (in the context of medical treatment) by Lord Goff in *Airedale NHS Trust v. Bland*:

'... [the] principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult 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.'⁹

The legal position, it would seem, is that disclosures of information designed to protect the patient who expressly withholds consent should not be tolerated unless the patient lacks capacity. However, the issue is more complicated than this would suggest. A lack of voluntariness renders any assent or refusal of assent meaningless. The Mental Capacity Act was designed to provide a single, comprehensive framework for people unable to make decisions for themselves. However, the test for capacity endorsed in the Act is not based on voluntariness. Paternalistic protection is limited to those who, 'because of an impairment of, or a disturbance in the functioning of, the mind or brain',¹⁰ are unable to make a decision.¹¹ A patient can be incapable of making a voluntary decision and yet retain capacity under the Act. Consider, for example, doctors who seek to protect

⁶ *Ibid.*

⁷ Mental Capacity Act 2005, s. 1(2).

⁸ Mental Capacity Act 2005, s. 4(6).

⁹ [1993] 1 *All ER* 821, [866].

¹⁰ Mental Capacity Act 2005, s. 2(1).

¹¹ Mental Capacity Act 2005, s. 3.

a patient from harm by reporting to the authorities their belief that the patient is being abused. The patient does not satisfy the test for incapacity set out in the Act but the doctor is satisfied that the patient's decision to withhold consent to disclosure is not in any meaningful way autonomous and a failure to act might lead to significant harm to the patient.

Three options remain: to respect the patient's decision even if there is a risk that it will lead to significant harm; to justify disclosure in the public interest; or to incorporate within the definition of incapacity decisions which are not voluntary. It is my contention that the third option is worthy of consideration. This flows in part from difficulties with the other options. The first choice is unattractive, at least where the harm caused by respecting confidentiality is judged to be more severe than the harm caused by its breach. But application of the public interest test to protect individuals who are vulnerable by reason of abuse in order to protect them from harm has potential to violate their human rights if they have expressly made what is viewed in law as a *capax* refusal to disclose the information. Human rights are universal in character. Where the European Convention on Human Rights applies, it applies to 'everyone', however vulnerable. In the context of the right to liberty, this point underpins Lady Hale's insistence in the Supreme Court decision of *P v. Cheshire West and Chester Council*¹² that a restriction on liberty remains a restriction regardless of its benevolent nature: 'an underlying public interest motive' is irrelevant. It is a principle central to the UN Convention on the Rights of Persons with Disabilities, Article 12 of which upholds equal recognition before the law. Article 22 requires that

'(1) No person with disabilities, ..., shall be subjected to arbitrary or unlawful interference with his or her privacy ... (2) States Parties shall protect the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others.'

The rights-based restrictions on the application of the public interest defence to breach of confidentiality do not preclude the protection of vulnerable people. They do, I shall argue, require that those protections are based on a lack of capacity which pervades despite efforts to empower the patient and that they are imposed only where it is in the best interests of the patient to do so.

Professional guidance

The law in England does not provide a clear answer to the conundrum of how to protect people whose decisions to withhold consent to disclosure of medical information lack voluntariness. The relationship between doctor and patient creates an obligation of confidence, but the duty is not abso-

¹² [2014] UKSC 19.

lute. The law has established several exceptions, which the General Medical Council (GMC) (and other relevant bodies) have interpreted and developed for application in clinical practice in a series of regularly updated professional guidelines. The GMC not only publishes advice to doctors on the standards expected of them, but also holds them to account. Thus the GMC plays a key role in both the development and enforcement of the law of confidentiality.

It might be expected that the guidelines were historically paternalistic and have given way to recognition of autonomy rights. To an extent this is true. Until 2000, it was accepted that information could be withheld from the patient, and the doctor could instead talk to a relative.¹³ Today, consent is the central justification for disclosure of confidential information.

When it comes to the disclosure of information to third parties against the wishes of a patient with legal capacity, however, as we shall see, the early guidelines are silent on the matter; later guidelines presumed the matter to be in the control of patients; but the most recent guidelines acknowledge that the patient might be overruled in the public interest. This is a surprising pattern, for it suggests an increasingly paternalistic attitude on the part of the GMC and this contradicts the wider move toward a healthcare system based on patient choice and autonomy. An examination of the history of the public interest and best interests defences reveals a potential explanation.

Public interest

In 1963, the GMC produced the first in its long series of ‘blue books’ on professional conduct,¹⁴ which recognised that ‘improperly disclosing information obtained in confidence from a patient’ may constitute ‘infamous conduct’. No guidance was offered as to what was improper and no exceptions to the general rule were articulated. A sentence was added in 1971 to explain that abuse of professional confidence could result in disciplinary proceedings.¹⁵ In 1977,¹⁶ the GMC set out for the first time a number of exceptions to the rule, quoting from the British Medical Association’s 1974 guidance.¹⁷ These included a number of defences including consent, legal requirement, medical research

¹³ Contrast with GMC, *Professional Conduct and Discipline* (1977), p. 16: ‘(c) the information regarding a patient’s health is given in confidence to a relative or other appropriate person, in circumstances where the doctor believes it undesirable on medical grounds to seek the patient’s consent...’ See www.gmc-uk.org/guidance/archive.asp (accessed 1 March 2015).

¹⁴ GMC, *Functions, Procedures, and Disciplinary Jurisdiction* (1963). See www.gmc-uk.org/guidance/archive.asp (accessed 1 March 2015).

¹⁵ GMC, *Professional Discipline* (1971), p. 9. See www.gmc-uk.org/guidance/archive.asp (accessed 1 March 2015).

¹⁶ See n. 13 above, p. 16.

¹⁷ BMA, *Medical Ethics* 1974, pp. 13-14.

and therapeutic privilege.¹⁸ The guidance also made mention for the first time of a public interest defence:

‘... rarely, the public interest may persuade the doctor that his duty to the community may override his duty to maintain his patient’s confidence.’¹⁹

In law, the public interest defence began life as a narrowly framed ‘iniquity defence’ in the case of *Gartside v. Outram*.²⁰ Lord Denning broadened its scope somewhat in *Initial Services Ltd v. Putterill*²¹ to include matters such as contemplated and committed crimes and frauds, but it was still broadly connected to wrongdoing. In *Beloff v. Pressdram*²² Ungood-Thomas J recognised that the same defence could apply to ‘matters medically dangerous to the public’. Only in the 1984 case of *Lion Laboratories Ltd v. Evans*,²³ was it recognised that the public interest is a balancing exercise extending beyond matters of wrongdoing.²⁴

In the 1989 leading case on the application of the public interest defence to medical confidentiality, *W v. Egdel*,²⁵ the court turned to the definition adopted by the GMC at the time. The GMC’s 1989 guidance was more detailed than the 1977 version, incorporating an example of its application: ‘... investigation by the police of a grave or very serious crime’,²⁶ thereby contributing to the view that the scope of the defence was limited to the prevention of harm to third parties (rather than to the patient).

A broader test was set down in 1993:

‘Rarely, cases may arise in which disclosure in the public interest may be justified, for example, a situation in which the failure to disclose appropriate information would expose *the patient*, or someone else, to a risk of death or serious harm.’²⁷ (Emphasis added.)

The threshold for the public interest to operate is set high – it will only apply to protect the patient from death or serious harm – but the public interest potentially defends disclosures designed solely to protect the patient.

¹⁸ See above n. 13.

¹⁹ *Ibid.*

²⁰ (1856) 3 Jur NS 39.

²¹ [1967] 3 All ER 145.

²² [1973] 1 All ER 241.

²³ [1984] WLR 539.

²⁴ J. Davis, *Intellectual Property Law* (OUP, 2012), p. 126.

²⁵ [1989] EWCA Civ 13.

²⁶ General Medical Council, *Professional Conduct and Discipline: Fitness to Practice*, ‘Professional Confidence,’ (1989) para. 81(g). See www.gmc-uk.org/guidance/archive.asp (accessed 1 March 2015).

²⁷ *Ibid.*, para. 86.

The ever-expanding sections on confidentiality and other matters necessitated a separate guide dedicated solely to confidentiality in 1995.²⁸ This was updated in 2000,²⁹ 2004³⁰ and most recently in 2009.

Inclusion in the 1995 guidance of a new section entitled 'Disclosure in the Interests of Others'³¹ might suggest a more restrictive stance, but the wording makes it clear that it applies in situations where a failure to disclose information could result in serious harm or death to *'the patient, or others'*.³² This was retained in the 2000 guideline, but with the addition of examples of situations in which the public interest defence might apply. These focused on situations when both the patient *and others* are at risk (e.g. driving against medical advice or when a colleague 'who is also a patient, is placing patients at risk due to illness').³³

The trend towards an ever more restrictive public interest test was continued in the 2004 guidance. This guidance accepts that disclosure where a patient has withheld consent may be justifiable 'where there is a serious risk to the patient or others'.³⁴ However the seemingly wide ambit of this defence is narrowed by the differentiation between cases where a lack of disclosure poses a serious risk to the patient or others *where it is not practicable to seek consent*,³⁵ (examples include incompetence, intractability, violence or emergency³⁶) and cases where a *third party* will suffer harm, in which case consent may be dispensed with. The implication is that the public interest in treating the patient without consent only applies where a patient with capacity does not expressly withhold consent.

The 2009 guidance bucks the trend. Reverting back to the position taken in 1993, the defence can (unusually) be invoked to protect patients who withhold consent:

'It may be appropriate to encourage patients to consent to disclosures you consider necessary for their protection and to warn them of the risk of refusing to consent, but you should usually abide by a competent adult's refusal to con-

²⁸ GMC, *Confidentiality* (1995). See www.gmc-uk.org/guidance/archive.asp (accessed 1 March 2015).

²⁹ GMC, *Confidentiality: Protecting and Providing Information* (2000). See www.gmc-uk.org/guidance/archive.asp (accessed 1 March 2015).

³⁰ GMC, *Confidentiality: Protecting and Providing Information* (2004). See www.gmc-uk.org/guidance/archive.asp (accessed 1 March 2015).

³¹ See above n. 28, p. 7.

³² See above n. 28, para. 18.

³³ See above n. 29, para. 37.

³⁴ See above n. 30, para. 24: 'In cases where there is a serious risk to the patient or others, disclosures may be justified even where patients have been asked to agree to a disclosure, but have withheld consent (for further advice see paragraph 27).'

³⁵ See above n. 30, para. 27.

³⁶ *Ibid.*, para. 23.

sent to disclosure, even if their decision leaves them, but nobody else, at risk of serious harm.³⁷

One must question whether it is justified at all. A brief examination of the evolution of the best interests test does, however, offer an explanation for this change in approach.

Best interests

The 1993 GMC guideline linked, for the first time, the best interests test and incapacity. Paragraph 84 deals with ‘immaturity, illness and mental incapacity which adversely affect understanding’, in which cases the best interests test will apply. A separate and additional defence is articulated in paragraph 83, which applies the best interests principle when a patient is ‘incapable of giving or withholding consent to disclosure’. The guidance is not clear as to what may have caused the incapability but gives an example: ‘One situation may arise where a doctor believed that a patient may be the victim of physical or sexual abuse’.

In the example given, an obvious source of incapability would be a lack of voluntariness. It recognises, therefore, that a person may have capacity and understanding but still lack the capability to consent. This advice was reiterated in 1995.³⁸ The dual routes to an inability to consent complied with the advice of the Law Commission’s 1995 report which recommended new legislation to effect a ‘unified approach’ to protect people who lack capacity and people in need of care and protection.³⁹

By 2000 the Lord Chancellor had taken forward a Green Paper on mental capacity,⁴⁰ and a policy statement on reform had been issued by the Department of Constitutional Affairs.⁴¹ The GMC issued new confidentiality guidance, retaining the application of the best interests when the patient lacked competence – whether due to ‘immaturity, illness, mental incapacity’,⁴² abuse or neglect.⁴³

³⁷ GMC, *Confidentiality* (2009), para. 51. See www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp (accessed 1 March 2015).

³⁸ See above n. 28, paras 10 and 11.

³⁹ The Law Commission, *Mental Incapacity* Law Comm No 231 (1995), para. 2.51 (and see 2.42-2.43).

⁴⁰ *Who Decides? Making Decisions on Behalf of Mentally Incapacitated Adults* (1997, Cm 3803), <http://webarchive.nationalarchives.gov.uk/+http://www.dca.gov.uk/menincap/meninfr.htm> (accessed 1 March 2015).

⁴¹ *Making Decisions* (1999, Cm 4465), <http://webarchive.nationalarchives.gov.uk/+http://www.dca.gov.uk/family/mdecisions/indexfr.htm> (accessed 1 March 2015).

⁴² See above n. 29, para. 38.

⁴³ *Ibid.*, para. 39.

Moreover, the Council maintained the dual routes in 2004 when the Mental Capacity Bill was making its way through parliament.⁴⁴

The Mental Capacity Act 2005 came into effect in 2007 and two years later, the GMC made further changes to its confidentiality guidance. In contrast to the 1995 Law Commission report, the Mental Capacity Act dealt purely with those who lack capacity, and did not address the protection of people who did not satisfy the test for incapacity but nonetheless required protection due to vulnerability on the basis of neglect, abuse, coercion or undue influence. This presented a problem. Previous versions of the confidentiality guidance had recognised that neglect or abuse may render a person unable to give or withhold consent. The GMC's 2009 guidance responded to the Mental Capacity Act by adding a new requirement that this will only hold true when patients lack capacity and disclosure is in their best interests.⁴⁵ The best interests test receives its most serious limitation to date. It only applies where a person is shown to lack capacity, as defined in the Mental Capacity Act. The GMC deals specifically with 'disclosures when a patient may be a victim of neglect or abuse',⁴⁶ recognising the validity of disclosures in the best interests of a person who is the victim of neglect or abuse. However, this is specifically confined to those who lack capacity.

Other guidelines

With one hand, the GMC limits the situations in which a doctor can disclose information to protect a patient by restricting disclosures in the patient's best interests to those situations where they lack capacity. With the other, it extends the public interest defence to allow (exceptional) disclosures to prevent serious harm to the patient. It is as though the GMC recognises the importance of protecting vulnerable people whose refusal to consent to disclosure put them at risk of serious harm and, finding the best interests route closed due to the restricted definition of incapacity favoured in the Mental Capacity Act, the Council reverts to the public interest test. The difficulty with this approach, as outlined above, is that the extension of the public interest to catch those decisions which are not truly voluntary but are, in law, *capax*, risks breaching the human rights of those individuals. The application of the public interest test in this regard threatens to undermine the protections to self-determination articulated in the Mental Capacity Act. To do so takes a charitable,

⁴⁴ See above n. 30, para. 28, and 29.

⁴⁵ See above n. 37, para. 63.

⁴⁶ *Ibid.*, para. 63.

paternalistic position which is not without support,⁴⁷ but which is at odds with the legal framework endorsed by parliament.

Other relevant guidelines are more restrictive of paternalistic disclosures. The Medical Protection Society guidance, updated in 2013, separates disclosure to protect the patient and disclosure to protect others:

‘If the patient has refused consent to the disclosure, you should consider any reasons provided by the patient. If you still consider that disclosure is necessary *to protect a third party from death or serious harm*, you should disclose information promptly to the appropriate person or authority.’⁴⁸ (Emphasis added.)

The British Medical Association’s toolkit on safeguarding⁴⁹ recognises that ‘Capacity is a vital concept in relation to the care and treatment of adults who may be vulnerable’ and that it is only appropriate to override a refusal of consent to disclose information where a criminal offence has or might be committed or there may be significant harm to a third party.

The Department of Health⁵⁰ 2010 guidance takes a similar position, recognising that disclosure to protect the individual is inappropriate unless to prevent a serious crime:

‘7. Is the disclosure necessary to prevent serious harm?’

It is important to distinguish between serious harm to the individual to whom information relates and serious harm to others. Confidential information can be disclosed without consent to prevent serious harm or death to others. This is likely to be defensible in common law in the public interest.

8. Where the patient is an adult lacking capacity, the Mental Capacity Act applies, and the best interests of the patient concerned can be sufficient to justify disclosure, i.e. information can be disclosed to prevent a patient who lacks capacity from being harmed.

9. However, an individual’s best interests are not sufficient to justify disclosure of confidential information where he/she has the capacity to decide for him/herself. There has to be an additional public interest justification, which may or may not be in the patient’s best interests.’

Whilst the final sentence leaves the position in a state of some ambiguity, when paragraph 9 is read in conjunction with paragraphs 7 and 8, it seems that

⁴⁷ S. Conly, *Against Autonomy: Justifying Coercive Paternalism* (CUP, 2012); M.A. Fineman, ‘The Vulnerable Subject and the Responsive State’ (2010) 60(2) *Emory Law Journal* 251.

⁴⁸ MPS, *Confidentiality – Disclosures without consent* (updated 2013), www.medicalprotection.org/uk/england-factsheets/disclosureswithoutconsent (accessed 1 March 2015).

⁴⁹ BMA, *Safeguarding vulnerable adults – a tool kit for general practitioners*, (2011), Card 6, p. 26, <http://bma.org.uk/-/media/Files/PDFs/Practical%20advice%20at%20work/Ethics/safeguardingvulnerableadults.pdf> (accessed 1 March 2015).

⁵⁰ *Confidentiality: NHS Code of Practice Supplementary Guidance: Public Interest Disclosures* (November 2010), www.gov.uk/government/uploads/system/uploads/attachment_data/file/216476/dh_122031.pdf (accessed 1 March 2015).

patients' best interests will not justify disclosure if they have capacity, and neither will the public interest, except to 'prevent serious harm or death to others'. In support of this interpretation, the advice goes on to provide examples of public interest defences, all of which include harm to others.⁵¹

The Department of Health guidance creates a distinction based on capacity. If the patient lacks capacity then the best interests test applies in conjunction with the public interest in protecting others from harm. If the patient has capacity then the interests of the patient (except where a crime has been or may be committed) is not a factor relevant to the public interest. The GMC, on the other hand, protects the patient from harmful and involuntary decisions through a wider interpretation of the public interest defence.

Involuntariness

Where an individual withholds consent to allow the doctor to disclose evidence of harmful abuse or neglect, a number of issues arise. On one hand, the patient's rights and interests in keeping the information confidential and public policy considerations around the need to ensure that people who suffer abuse feel able to talk frankly to healthcare professionals militate against disclosure. On the other hand, the desire to bring the perpetrators to justice and the uncertainty regarding the validity of the abused person's refusal to consent to disclosure may provide reasons to overrule the patient. What has the law to say on the matter? Scotland and Wales have enacted legislation – the Social Services and Well-being (Wales) Act 2014⁵² and the Adult Support and Protection (Scotland) Act 2007⁵³ – to require doctors and other agencies to notify local authorities where an adult is at risk of abuse.

In England, the route is significantly less clear. Where neglect or abuse is a result of failures in health or adult social care, new reporting requirements introduced in section 81 of the Care Act 2014, create a statutory duty of candour.⁵⁴ Section 42 of the Care Act 2014 imposes on local authorities a new legal duty to make enquiries where they have reasonable cause to suspect that an adult

⁵¹ *Ibid.*, para. 11.

⁵² Social Services and Well-being (Wales) Act 2014, s. 106(1): 'If a relevant partner of a local authority has reasonable cause to suspect that a person is an adult at risk and appears to be within the authority's area, it must inform the local authority of that fact.'

⁵³ Adult Support and Protection (Scotland) Act 2007, s. 5(3): 'Where a public body or office-holder to which this section applies knows or believes – (a) that a person is an adult at risk, and (b) that action needs to be taken (under this Part or otherwise) in order to protect that person from harm, the public body or office-holder must report the facts and circumstances of the case to the council for the area in which it considers the person to be.'

⁵⁴ The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014/2936, Reg 20.

in their area with care and support needs is at risk of abuse or neglect. However, in contrast to the position in Scotland and Wales, there is currently no proposal to impose a duty on the NHS and other agencies to notify a local authority where they believe an adult may be at risk of abuse. Local authorities will be reliant on the good will of agencies (such as the NHS) referring cases to them. But, contrary to Scotland and Wales, the position taken by parliament in England is to place greater emphasis on the individual's right to make the decision about disclosure. Provided no-one else is at risk of harm, the common law public interest defence has no relevance here. To use it would be to make a best interests decision by another name. Accordingly, the British Medical Association recognises that 'competent adults have the right to make decisions about how they manage the risks to which they are exposed and such decisions should ordinarily be respected'.⁵⁵

Protecting vulnerable patients by invoking the common law public interest defence is an understandable reaction to the tension created by the legal restrictions on the application of the best interests test and the state duty to protect vulnerable people from abuse, but it is, I submit, inherently problematic. In addition to subverting the will of parliament, and having the potential to breach human rights by limiting a decision-making authority on the basis of vulnerability, there is an additional inherent danger. The public interest defence is essentially consequentialist in nature and is focused on the public health rather than the individual rights of the patient. The more appropriate defence to disclosure designed to protect the patient from harm is the best interests defence, which is designed to protect the personal interests of people who cannot make autonomous decisions. There are protections incorporated within the Mental Capacity Act, which requires facilitation of autonomous decision making and reference to the views of the patient. These safeguards are not relevant to the public interest defence.

Extension of the best interests defence to incorporate involuntary decisions

If we accept that decisions to overrule a patient's refusal to disclose information designed purely to protect the patient from harm can only be justified by virtue of statute or the best interests defence, then it is important to explore the ambits of the best interests defence.

The Mental Capacity Act is framed to allow doctors to make decisions in the patient's best interests where the doctor is satisfied on the balance of prob-

⁵⁵ BMA, *Vulnerable adults and the disclosure of confidential information* available at <http://bma.org.uk/practical-support-at-work/ethics/mental-capacity/vulnerable-adults-and-confidentiality> (accessed 1 March 2015).

abilities that the person lacks capacity. The Act lists in section 4 the various factors which must be considered in making a best interests decision: the person in question must be allowed to participate as fully as possible;⁵⁶ and his or her past and present wishes must be taken into account.⁵⁷ Of the legal defences currently available, this rather than the public interest test is more relevant to the protection of the patient's personal interests. If the Act does not apply, then arguably doctors have no business imposing their decisions upon the patient. However, an alternative means of protecting vulnerable people has recently emerged. More accurately, it has existed for a long time, but has recently been confirmed to have survived the implementation of the Mental Capacity Act.

We have seen that, before the Mental Capacity Act was enacted, the GMC applied the best interests test to two groups. The first covered those who lacked the ability to consent or to refuse to consent by virtue of 'immaturity, illness and mental incapacity'. Post-1990 it was recognised in law that where someone in this group could not give a valid consent, the doctrine of necessity would apply when treatment was in a patient's best interests.⁵⁸ Today, this group are protected by virtue of the Mental Capacity Act test for incapacity, which is designed to identify those who, as a result of an impairment of the mind or brain, lack the requisite understanding to make the decision in question.⁵⁹

The best interests test also applied to a second group; those suffering abuse, neglect or other factors which are largely due to the intervention of a third party, which rendered them 'unable to consent'. Munby J has described the group in the following way:

'I would treat as a vulnerable adult someone who, whether or not mentally incapacitated, and whether or not suffering from any mental illness or mental disorder, is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation, ...'⁶⁰

Historically, the common law inherent jurisdiction provided that where a patient makes an involuntary decision – perhaps due to duress or coercion – consent is not valid⁶¹ and the court has powers to safeguard the person concerned.⁶² Post-Mental Capacity Act, it was unclear whether or not that inherent jurisdiction remained. As we have seen, this legal lacuna is a potential explanation for the extended remit of the public interest test in the GMC guidance, so as to afford such patients the necessary protection.

⁵⁶ s.4(4).

⁵⁷ s.4(6).

⁵⁸ In *Re F (Mental patient: Sterilisation)* [1990] 2 AC 1.

⁵⁹ ss. 2, 3.

⁶⁰ *Re: SA (vulnerable Adult with Capacity: Marriage)* [2005] EWHC 2942 (Fam), at [81]-[83].

⁶¹ *Re T (Adult: Refusal of Treatment)* [1993] Fam 95.

⁶² See above n. 60.

The legal ambiguity was recently resolved in the case of *DL v. A Local Authority & Others*.⁶³ There it was recognised that the Mental Capacity Act does not expressly limit the inherent jurisdiction of the court. It was held that the test for incapacity set out in the Act is not exhaustive: the inherent jurisdiction of the High Court remains. McFarlane LJ made it clear that, where the inherent jurisdiction is applied, it must be applied in a manner compatible with the principles of the Act. In particular, it may fall foul of Article 8 of the European Convention of Human Rights if it is used to remove an adult's decision-making autonomy. The Court of Appeal endorsed the view expressed in *Re SA (Vulnerable adult with capacity: marriage)*⁶⁴ that the inherent jurisdiction:

'... is in part aimed at enhancing or liberating the autonomy of a vulnerable adult whose autonomy has been compromised by a reason other than mental incapacity because they are ... (a) under constraint; or (b) subject to coercion or undue influence; or (c) for some other reason deprived of the capacity to make the relevant decision or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent.'

Having resolved the question of whether the inherent jurisdiction applies, the Court considered the potential remedies at its disposal. McFarlane LJ commended 'a facilitative, rather than a dictatorial approach'⁶⁵ on the basis that it is 'entirely on all fours with the re-establishment of the individual's autonomy of decision making in a manner which enhances, rather than breaches, their ECHR Article 8 rights'.⁶⁶ McFarlane LJ praised the similar approach taken by Macur J in *LBL v. RYJ and VJ*.⁶⁷

This would imply that a recognition of incapacity flowing from undue influence would not enable the court to impose its own substituted decision in the best interests of the patient. Two factors suggest that, whilst this was clearly the intention in the case before the court, it does not signify the extent of the High Court's powers.

First, McFarlane quoted Munby J in *Re SA*, saying:

'It is now clear, in my judgment, that the court exercises what is, in substance and reality, a jurisdiction in relation to incompetent adults which is for all practical purposes indistinguishable from its well-established *parens patriae* or wardship jurisdictions in relation to children. The court exercises a "protective jurisdiction" in relation to vulnerable adults just as it does in relation to wards of court.'⁶⁸

⁶³ [2012] *EWCA Civ* 25.

⁶⁴ See above n. 60, [54].

⁶⁵ See above n. 63, [67].

⁶⁶ See above n. 63, [67].

⁶⁷ [2010] *EWHC* 2665 (COP), [62].

⁶⁸ [2005] *EWHC* 2942 (Fam), [37]; [2012] *EWCA Civ* 25, [14].

The court can make a decision in the best interests of children and the implication is that they might do so, where necessary, for adults.’

Secondly, McFarlane LJ’s states:

‘I reject the idea that, if it exists, the exercise of the inherent jurisdiction in these cases is limited to providing interim relief designed to permit the vulnerable individual the “space” to make decisions for themselves, removed from any alleged source of undue influence. Whilst such interim provision may be of benefit in any given case, it does not represent the totality of the High Court’s inherent powers.’⁶⁹

DL has since been applied and referred to in a number of decisions. In *Nottinghamshire Healthcare NHS Trust v. RC Mostyn J* said:

‘[A]dults who have capacity but who can be categorised as “vulnerable” and who as a consequence of their vulnerability have been robbed of the ability to give a true consent to a certain course of action, may also have treatment or other measures imposed on them in their best interests pursuant to the inherent jurisdiction of the High Court.’⁷⁰

In *DL v. A Local Authority & Others* and *LBL v. RYJ and VJ*, the court had within its power the potential to remove the barrier to the person making a *capax* decision. Were the facts different – were the situation such that the removal of the physical presence of the abuser did not result in the influence being removed, for example, or, in the case of disclosure of information, the support necessary to enable the person to make other important unencumbered decisions was dependent upon an initial breach of confidentiality – then arguably the court would wish to substitute its own decision for that of the patient. Where so, it makes sense to comply with the framework set out in section 4 of the Mental Capacity Act. Whether the disclosure would be in the best interests of the patient would depend on the facts.

It is clear at present that this is a jurisdiction limited to the High Court.⁷¹ Where a vulnerable patient refuses consent to disclosure and there is doubt as to the voluntariness of their decision, if that decision does not fall within the definition of incapacity set out in the Mental Capacity Act, consideration should be given to approaching the High Court to exercise its inherent jurisdiction, in order to prevent serious harm.

⁶⁹ See above n. 63, [68].

⁷⁰ [2014] EWHC 1317 (COP), [13].

⁷¹ *Ibid.*, [17].

Conclusion

We are heading towards an increasingly comprehensive model of legal capacity. Statutory and common law articulations result in a complex set of rules. The Mental Capacity Act was designed to constitute a single legislative framework to govern decision making by people incapable of making autonomous decisions for themselves. However, the test set down in sections 2 and 3 focused on a particular type of incapacity – that which flows from an impairment of the mind or brain. Those whose ability to make autonomous decisions is adversely affected by the interventions of third parties are offered only limited protection by virtue of the Act. This has necessitated other means of protecting vulnerable people whose decisions put them at risk of serious harm. The GMC's *Confidentiality* guidelines have responded to legal developments by periodically revisiting and rearticulating the ambits of the best interests and public interest defences to breach of confidentiality.

We now know that the Mental Capacity Act test is not exhaustive. Those who cannot decide by reason of coercion, undue influence or other factors may lack capacity at common law. There is scant knowledge or understanding of this alternative test for capacity and how it might operate in clinical practice. The law has sketched out the new test in the most basic of forms. The case law is gradually filling in some of the gaps. A doctor, whose patient refuses to allow disclosure of confidential information that may lead to significant harm to the patient alone, has a range of options. If a strong policy issue has justified legislative intervention to mandate disclosure, then the doctor must pass on the information. If, in addition to harming the patient, non-disclosure may lead to harm to a third party, then disclosure may be justified in the public interest. If the patient lacks capacity under the Mental Capacity Act, the doctor may be able to make the disclosure in the best interests of the patient. But if the patient retains capacity but lacks the ability to make a voluntary consent or refusal then, as the law stands, the doctor should apply to the High Court to exercise its inherent jurisdiction. Post *DL v. A Local Authority & Others*, further revision of the GMC guidance would be prudent in order to reflect the latest articulation of the legal test for capacity and to enhance conceptual consistency in the clinical application of the best interests and public interest defences.