Cobden House
CHAMBERS

Clinical Negligence and Human Rights – An additional dimension

On 3 August 2017 general surgeon Ian Paterson, who was convicted of 17 counts of wounding with intent and three counts of unlawful wounding in relation to carrying out unnecessary breast procedures, had his sentence of imprisonment increased from 15 years to 20 years on account of "exceptionally high" levels of harm and culpability.

"Good Medical Practice" sets out the duties of a doctor registered with the General Medical Council and asserts that "*Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible whatever their illness or disability*".

The facilitation of human dignity is a recurring theme at the heart of healthcare ethics and reflected in our legal values. The protection and promotion of human dignity also underpins the European Convention on Human Rights as clarified in the Charter of Fundamental Rights of the European Union, which declares at the beginning of its pre-amble: "*Conscious of its spiritual and moral heritage, the Union is founded on the indivisible, universal values of* ***human dignity****, freedom, equality and solidarity. It is based on the principles of democracy and the rule of law.* ***It places the individual at the heart of its activities*****…..**"[1]

It is therefore not surprising, and to my mind, to be welcomed that, increasingly, decisions concerning health issues are analysed through the prism of human rights values. By way of recent examples, Briggs[2] [2017] clarified the correct procedure for determining the best interests of a minimally conscious patient, including the desirability and legality of the deprivation of liberty safety (DoLS) regime against the background of ECHR Article 5[3]. The Human Rights Act 1998 also allows claimants to bring claims for damages under the Act when other statutes or common law remedies are unavailable or insufficient- see Rabone v Pennine Care NHS Foundation Trust [2012] UKSC 2 where the claimant-parents of an adult child successfully obtained damages for their daughter's death in circumstances where they were not entitled to damages under the Fatal Accidents Act 1976. At the other end of the legal spectrum, in a more run-of-the-mill clinical negligence decision arising out of negligent

[1] Preamble to Charter of Fundamental Rights of the European Union which became legally binding on EU institutions and national governments with the Treaty of Lisbon in 2009, albeit that the Charter merely informs our law and has not been formally incorporated into our domestic law, (unlike the ECHR).
[2] [2017] EWCA Civ 1169
[3] Right to liberty and security

treatment by nursing staff in Hegarty v University Hospitals Birmingham[4], HHJ Platts[5] did not consider that the breaches engaged Articles 3 and 8[6].

The 2015 decision of Montgomery v Lanarkshire Health Board[7] notes that the courts have become increasingly conscious of the extent to which the common law reflects fundamental values under the "stimulus" of the Human Rights Act 1998[8] and affirms, inter alia, that Article 8 respect for private life requires healthcare professionals to involve the patient in decisions relating to treatment. The factual issues in Montgomery highlighted the tensions between: the vulnerabilities of a baby during the hazardous process of birth; the risks to the mother and her Article 8 rights to autonomy at the time of birth; and the obstetrician's professional opinion about, and assessment of, the risks and best interests of both baby and mother, in that case, at the time of considering the advisability of a caesarean section. Hale LJ pointedly commented at the end of the judgment that "*gone are the days when it was thought that, on becoming pregnant, a woman lost, not only her capacity, but also her right to act as a genuinely autonomous human being.*"[9]

Elective breast surgery might engage Article 8 rights and the relationship between patients and healthcare professionals in an entirely different way though. When breast reduction or enhancement surgery is indicated as a result of predominantly physical considerations, (such as a result of trauma, or mastectomy due to cancer or following numerous pregnancies and lactation or perhaps following change caused by significant weight loss for whatever reason), it is easy to imagine the content of the conversation between the health professional, especially a surgeon, and the patient. This would no doubt include acknowledgement that surgery, (assuming it was successful), would be likely to bring psychological benefits.

However, where a woman seeks breast surgery purely for reasons which are linked to considerations of self-image and self-esteem without an "obvious" physical deficit, then what is the character of her autonomy and what is the role of Article 8 in her expression of her assertions of personal dignity? To what extent should human rights jurisprudence protect decisions to undergo "purely" cosmetic surgery as an expression of her privacy and dignity?

For some, breasts, more than any other organ, embody the tension for women between eroticism and nurture, pleasure in attracting a mate and the additional burden of graft involved in pregnancy, labour, breast-feeding and raising children, that falls on women. Breasts represent much emotional baggage for women and, indeed for men. It is therefore welcomed that the Court of Appeal have marked the seriousness of Mr Paterson's crimes and noted the vulnerability of his patients.

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[4] LTL 26/6/2017 Extempore 23/06/2017
[5] Sitting in the QBD
[6] In part because the claims were not brought within the 12 month deadline
[7] [2015] UKSC 11
[8] Ibid para 80
[9] Ibid para 116

Given the convictions at the criminal standard of proof, Mr Paterson's surgical activity was a blatant disregard for his duty of care. However, the tension between a patient's right to assert her autonomy in requesting breast "enhancement" surgery, and a healthcare professional's obligations to honour the patient's dignity create tensions. An interpretation of Montgomery might suggest that healthcare professionals should not seek to dissuade fully-autonomous women from having breast enhancement surgery, as long as all the risks, disadvantages and pitfalls are comprehensively and neutrally explained to them. However, indirectly, this supports the activities of entrepreneurial private surgeons offering this type of cosmetic surgery and potentially supports a culture of health services provided for financial consideration, and ultimately, profit. In some cases, this scenario has the potential to turn human insecurity into a commodity to be exploited in the name of enhancing privacy and dignity.

So, a complication of reinforcing human rights values, particularly Montgomery–respecting autonomy, in healthcare decisions within the cosmetic surgery "industry", might be that patients become more vulnerable to opportunistic healthcare service providers seeking to profit from their patients' insecurities and anxieties, arguably generated in part by a public visual and media culture which promotes images of (often airbrushed) unobtainable perfection and which denigrates people with "normal" physique.

As is so often the case, more danger and pitfalls go with the territory of enhanced freedom and opportunity. Protecting greater rights to autonomy involves individuals taking greater responsibility for those decisions in the sense of living with the consequences if things work out to their disadvantage. However, the idea that the contractual values of "caveat emptor" should be applied to provision of healthcare "services" which have been provided negligently runs counter to traditional values of tort law which embody ethical values, such as Lord Atkins "neighbour" principle[10], duty of "care" as well as concepts of human dignity.

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[10] Donaghue v Stevenson (1932)