影印版法学基础系列

医疗法基础

ESSENTIAL MEDICAL LAW

布伦丹·格瑞尼
Brendan Greene

全国优秀出版社
武汉大学出版社

影印版法学基础系列

医疗法基础

ESSENTIAL MEDICAL LAW

布伦丹·格瑞尼
Brendan Greene, LLB, MA

全国优秀出版社
武汉大学出版社

图书在版编目(CIP)数据

医疗法基础＝Essential Medical Law/(英)布伦丹·格瑞尼(Brendan Greene)著. —武汉：武汉大学出版社，2004.6
(影印版法学基础系列)
ISBN 7-307-04226-6

Ⅰ.医… Ⅱ.布… Ⅲ.卫生法—英国—高等学校—教材—英文
Ⅳ.D956.121

中国版本图书馆 CIP 数据核字(2004)第 034286 号

著作权合同登记号：图字 17-2004-010

责任编辑：王军风　张　阳　　版式设计：支　笛

出版发行：**武汉大学出版社**　(430072　武昌　珞珈山)
(电子邮件：wdp4@whu.edu.cn　网址：www.wdp.whu.edu.cn)
印刷：武汉大学出版社印刷总厂
开本：920×1250　1/32　印张：6　字数：241 千字
版次：2004 年 6 月第 1 版　　2004 年 6 月第 1 次印刷
ISBN 7-307-04226-6/D·565　　定价：10.00 元

本书导读

法律不仅仅是关于道德与公理的原则，也不单单是说理论道的公平教义，它还应具有可操作性。这本医疗法教材关乎医学专业，因而体现更为精细的专业技术与经验，包含了以众多案例积累而成的经验与知识。

本书内容精炼，语言深入浅出，独具特色。全书共分九章对医疗法的若干基本问题作了高度的概括和浓缩。第一章对医疗法从广义上以及人权法案(1998 年)的角度予以简单的介绍。第二章重点讲述患者对于治疗的同意表示问题，从患者同意表示的能力、刑法、民法、医生职业守则和人权法案(1998 年)等方面对这一问题予以阐述。第三章专门介绍了儿童及其同意表示的效力问题。第四章的内容是医疗过失。作者首先阐释了过失侵权行为的要件，然后对转承责任、过失医嘱、精神损害、医疗过失的刑事责任等问题结合所涉及的限制法案、消费者权益保护法和人权法案进行了具体论证。第五章是关于医疗机密和患者查看病历的权利问题。作者从普通法的规则入手，论述了艾滋病的医疗机密性、保密义务的法定例外情况以及医务人员违反保密义务的损害赔偿问题，最后讨论了患者查看病历的权利问题。第六、七、八和九章则是与生物伦理道德联系相对紧密的有关医疗法上的问题，结合人权法案(1998 年)分别谈到了生育法、堕胎、医疗法上的死亡与安乐死、人体器官的所有权和器官移植等方面的法律问题。

在具体论述中，作者首先在每章的开篇都列出读者需要熟知的相关理论和法律规定，以便读者深入理解相关章节的内容；然后对本章的内容做出提示和概要介绍，这种提纲挈领式的简介可帮助读者获得总体把握。在论证过程中，作者采用了以判例和相关资料来充实理论的写作手法，强调法律在具体案件中的运用，避免只灌输法律的理念与规定而忽视培养解决实际问题能力的弊端。作者以简洁生动的语言阐述了医疗法的基本制度，使读者易于准确了解和把握医疗法的精髓。精心选取的案例，周全到位的点评，使读者对所述问题均易获得清晰思路，并能举一反三地灵活运用。

本书向学习者提供了一个了解医疗法的快捷途径。它尤其适合于有紧迫压力感的法律专业及其他相关专业的学生，因为本书的内容以及编排设

计都会向读者提供异于其他基础教材的补充性、修正性的帮助，可有效提高学生理解概念、把握精义以及分析与解决问题的能力。本书亦可为对医疗法及相关问题感兴趣的一般读者提供一个了解相关学科背景及资料的简易途径。

本书的目录和索引部分由张阳翻译，不当之处敬请专家、读者指正。

译　　者

2004 年 5 月

Foreword

This book is part of the Cavendish Essential series. The books in the series are designed to provide useful revision aids for the hard-pressed student. They are not, of course, intended to be substitutes for more detailed treatises. Other textbooks in the Cavendish portfolio must supply these gaps.

Each book in the series follows a uniform format of a checklist of the areas covered in each chapter, followed by expanded treatment of 'Essential' issues looking at examination topics in depth.

The team of authors bring a wealth of lecturing and examining experience to the task in hand. Many of us can even recall what it was like to face law examinations!

Professor Nicholas Bourne AM
General Editor, Essential Series
Conservative Member for Mid and West Wales
Spring 2001

Preface

Medical law provides a uniquely challenging area of study, because of both its intellectual demands and the fact that, by its nature, it will have an impact on our individual lives. This book has two aims: first, to provide an introduction and overview of the main legal and ethical issues arising in medical law; and, secondly, to provide a revision aid for the student facing examinations.

The book explains the main principles of medical law and includes important legislation, cases and extracts from codes of conduct. Reference is made to academic articles, journals and standard academic works throughout the text.

The book may also serve as an introduction to the subject for those who work in the medical field, including staff in the National Health Service.

My thanks are due to the staff at Cavendish Publishing for their support in writing this book, and in particular to Ruth Massey. I have endeavoured to state the law as it stood on 1 January 2001.

Brendan Greene
January 2001

Contents

目　录

1 Introduction to Medical Law

You should be familiar with the following areas:

- deontological and utilitarian theories
- distinctions between civil and criminal law; the courts likely to be used in medical law; claims in contract; judicial review
- human rights and Articles of the European Convention on Human Rights (incorporated in Sched 1 to the HRA 1998)

Introduction

Medical law touches the lives of everyone and raises fundamental questions about life, death and many of the things which happen in between those two events in peoples' lives. The law attempts to deal with a wide range of problems, such as what to do with patients who refuse treatment or patients who are unable to consent to treatment; how to respond to the increasing number of claims for medical negligence; and what rights children have in respect of treatment. There are many contemporary issues with which the law has to grapple, including whether there should be an automatic right to abortion, when organs may be removed from dead patients and whether to legalise the practice of euthanasia. The ethical and legal dilemmas have recently been highlighted by the discovery of the practice of removing organs from dead children at Alderhey Hospital in Liverpool and at Bristol Royal Infirmary and by the case of the conjoined twins, Jodie and Mary.

Ethical theories and principles

Medical law is not simply a set of rules which can be applied to solve legal problems, because it frequently involves questions of morals – whether particular actions are the right thing to do – for example, the

issue of abortion. Ethical rules are important because ethical principles sometimes underpin legal rules; for example, the law on consent to treatment is based on the principle of autonomy. Sometimes, there are no legal rules, or the rules are unclear and decisions have to be made on the basis of ethical principles, for example, if tissue is taken from a dead body. There is also the question of individual moral perspectives – clearly, the law cannot satisfy everyone, as people have conflicting moral views. What should the role of the law be in such conflicts? Should it be a matter for the individual to decide, or should the law impose limits on people's rights? Again, the example of abortion may be used. A second example is the conflict between the parents of Jodie and Mary, who did not want the twins to be separated, and the doctors at St Mary's Hospital, Manchester, who *did* want to separate the twins.

There are two main ethical theories: deontological – which is based on what is the right thing to do in any particular circumstances; and utilitarianism – which aims broadly to maximise happiness and evaluates an action on the consequences of that action:

- Deontological theory: 'deon' means duty and this approach determines whether an action is right by asking if there is a duty to do it or not, for example, a duty not to kill. Immanuel Kant was a proponent of this theory and believed that it could be used to judge whether any particular act was morally right or wrong. This approach tends to look for principles which can be followed, for example, the principle of autonomy. Autonomy means 'self-rule' and its wider meaning is to think and act freely. In a medical context, the doctor would be under a duty to respect the patient's autonomy.
- Utilitarian theory: this judges an action by what its consequences are, with the aim of maximising happiness. Jeremy Bentham and JS Mill were exponents of this theory. It can be seen as a 'goal-based' approach, the goal being to maximise the benefit, or welfare, to society. An action is right if it has good consequences and the nature of the action does not matter. It does not take a stand on principle but simply looks at the consequences. For example, it would not consider abortion wrong in itself because it offends the principle of the 'sanctity of life', but would judge it on its overall effect on society. A utilitarian approach will breach duties and violate rights if this maximises the good.

Apart from ethical theories, there are a variety of moral principles which play an important part in medical law and ethics. These include the principles of autonomy, beneficence (to do good), non-maleficience (to do no harm) and justice (to treat people fairly). The traditional approach in medicine was based on the principle of beneficence, in that doctors saw their role as helping patients. All too often, this became 'doctor knows best' and many doctors took a paternalistic approach to their patients. Over the last 30 years, patients' rights have grown more important and the principle of autonomy has come to the fore.

The wider context of medical law

Civil and criminal law

Although medical law is now recognised as a separate branch of law, it must be remembered that it operates in the wider context of the legal system. The distinction between civil and criminal law must be borne in mind and, although most matters of medical law will be civil ones, the criminal law will sometimes be relevant. This distinction between civil and criminal is reflected in the court structure and medical staff may need to attend both civil and criminal courts. One act may involve both civil and criminal liability: for example, if a member of staff hit a patient (or, more likely, a patient hit a member of staff!), this would be battery in civil law and an criminal assault under the Offences Against the Person Act 1861. Minor criminal matters such as assault will go to the magistrates' courts and more serious offences, such as manslaughter, will be dealt with at the Crown Court. A violent, unnatural or sudden death must be reported to the coroner, who may order a post mortem or hold an inquest. An inquest will take place in a coroner's court.

In civil law, negligence claims may be brought on the basis of a conditional fee agreement ('no win, no fee'). The lawyers for the winning side may claim a success fee of up to 100% for the case and this applies to all civil claims, including clinical negligence (formerly medical negligence), with the exception of family matters. Formerly, although the losing party did not need to pay their own lawyer, they did have to pay the other side's costs and take out an insurance policy to cover this. For medical negligence cases, the insurance premium could be thousands of pounds, which meant that many people would not take the risk of bringing a claim. Since 1 April 2000, under the

Conditional Fee Agreements Regulations 2000, the success fee and the insurance premium may be recovered from the other party under a costs order.

Lord Woolf's reforms of the civil justice system included the use of 'pre-action protocols'. The aim of the 'clinical negligence protocol' is to try to settle claims before they reach court. The claimant sends a 'preliminary notice' to the other side, setting out brief details and the value of the claim, and the other party must acknowledge this within 21 days. The parties may then decide to go through an alternative dispute resolution (ADR) procedure, under which they try to settle the claim. The next stage is a more detailed letter of claim, which must be acknowledged within 21 days. The parties should then conclude negotiations within six months. If the case should continue to court, then the procedure is set out in the Civil Procedure Rules 1998. These provide a common set of rules for both the County Court and the High Court. The court now takes an active part in the management of cases and also allocates each case to one of three 'tracks':

(a) the small claims track, which deals with claims under £5,000. Claims for personal injury must be no more than £1,000 to be allocated to this track. Parties cannot claim their legal costs from the other side;

(b) the fast track, which is for claims up to £15,000 where the trial is not expected to last for more than one day. Only one oral expert is allowed for each party;

(c) the multi-track, for claims over £15,000 and for complex cases. Most medical negligence claims will be multi-track claims and, if they are for over £50,000, will be heard in the High Court.

Claims in contract

Patients who suffer harm as a result of NHS treatment can sue for negligence. But can they sue for breach of contract? A patient receiving treatment from the NHS does not have a contract with the NHS and cannot sue for breach of contract if they suffer harm. Arguments have been put forward that a contract does exist. In *Pfizer v Ministry of Health* (1965), the House of Lords considered whether a patient paying for a prescription under the NHS was a contract. The House of Lords said that there was no contract between a patient and the NHS, even though a payment was made. A contract was marked out by the fact that it was a voluntary agreement, but pharmacists were under a