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COMMENTARY

WITHHOLDING MEDICAL RECORDS WITHOUT EXPLANATION: A FOUCAULDIAN READING OF PUBLIC INTEREST

Roberts *v* Nottinghamshire Healthcare NHS Trust

[2008] EWHC 1934 (QB).

Introduction

The claimant, Clive Roberts, was convicted in 1989 of a violent offence. Adjudged to be suffering from a mental disorder, he was detained at Rampton Hospital under the Mental Health Act 1983. After moving between a variety of high and medium secure units, he was readmitted to Rampton in 2004, where he is currently receiving treatment for a psychotic delusional disorder and bi-polar affective disorder. In December 2007, Robert's solicitors asked for disclosure of a medical report on him prepared by a psychologist, A, under s 7(1) of the Data Protection Act 1998. The report constituted, in the words of the defendant NHS Trust, a 'lengthy, unedited and largely verbatim statement from Mr Roberts outlining his version of his history'.[1] The Trust refused disclosure on account of 'a number of concerns' it had.[2] It stated that further psychological evidence was being sought from B, who was to replace A, as Roberts's named psychologist.

An application was made for disclosure pursuant to s 7(9) of the 1998 Act in the course of a Mental Health Review Tribunal (MHRT) hearing; but this was rejected: the defendant, it was said, did not intend to rely on the report at the forthcoming hearing—it preferring the report prepared by B; furthermore, there was no statutory duty to disclose the report to the Tribunal; and in any event the claimant could rely on his own independent psychological report. The MHRT hearing was adjourned to allow Roberts to gather expert evidence. In the meantime, a further request for disclosure was made to the defendant, which it declined, merely alluding to the 'number of reasons for which access to medical records can be restricted or declined'.[3]

Counsel for the claimant adopted a two-fold approach to seeking disclosure. First, arguing that the data controller had failed to

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1 At [17].
2 At [4].
3 At [8].

communicate personal data to Mr Roberts, in accordance with s 7(1), and that therefore the Court should order full disclosure under s 7(9). Secondly, in the event that full disclosure was deemed inappropriate, drawing on the distinction made in s 15(2) of the 1998 Act between the claimant and his or her representatives, his counsel asked that the court disclose the report only to his legal team, as permitted by rule 12(3) of the Mental Health Tribunal Rules 1983. Cranston J was unmoved by both submissions. A Special Advocate (SA, an appointed lawyer, who is usually a barrister) was subsequently appointed to hear the defendant's reasons for non-disclosure in closed court.[4]

Extending the Remit of the SA

The role of SA was originally intended for the Special Immigration Appeals Commission (SIAC) where elements of national security may prevent the claimant from seeing sensitive documents.[5] More recently, in other legal contexts, where no such statutory provision exists, courts have increased applications to the Attorney-General to have appointed an SA in closed court conditions. In *Malik v Manchester Crown Court*,[6] however, it was warned that, in general, appointments should only occur if it is likely to further the absent party's case,[7] and then only if the claimant asks for one.[8]

In respect of *Roberts*, *Malik* creates a paradox: on one hand, it is said that the common law requirements of natural justice are satisfied in cases where the claimant is *ex parte*, for the court will represent their interests.[9] On the other hand, as in *Roberts*, even if the claimant wishes to argue his or her case in person, and therefore the defendant's reasons for non-disclosure, an SA may still be appointed. This is despite the concern that it may not always be possible for the court to form a view 'as to how far, realistically, a Special Advocate is likely to be able to advance the party's case'.[10]

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4 The judge can order that there be an open and closed judgment where there are public interest issues at stake.

5 See Special Immigration Appeals Commission Act 1997 s 2.

6 [2008] EWHC 1362 (Admin).

7 At [102].

8 Only in this situation, for the purposes of Art. 6 of the Convention (right to a fair trial) can the judge be argued to have erred in not providing one: at [104].

9 Of course, the defendant must also lay before the court material which undermines his or her case.

10 At [102]. In general, they face the disadvantage that, once they have seen the sensitive material, they cannot take instructions; they lack the resources of an ordinary legal team for the purposes of building a defence; and they have no power to call witnesses. See Constitutional Affairs Committee, 'The Operation of the Special Immigration Appeals Commission (SIAC) and the Use of Special Advocates: Seventh Report of the Session 2004–05' HC (2004–05) 323–I at [52].

It was, presumably, this concern combined with the contentious nature of preventing a claimant from hearing reasons for non-disclosure *per se*, that Lord Bingham said that the appointment of an SA will always be 'exceptional, never automatic; a course of last and never first resort'.[11] Yet, the appointment in *Roberts* may well have the opposite effect: with the court having refused to furnish the claimant and his counsel (through adopting a flexible approach to the DPA) with the Trust's reasons for non-disclosure, the logic of Cranston J provides that in future cases of this ilk, there may be no other way to protect the interests of the claimant *but* to appoint an SA. This will do little to assuage long-standing concerns that the judiciary too readily defer to medical decision-makers; it will also mean that whatever the underlying basis of those decisions, few will hear them.

Moreover, it is unlikely that marshalling the appointments scheme within a statutory framework will make the system of non-disclosure fairer. As one SA expressed, on behalf of nine of the then current 13 SA's within the SIAC:

> We do not consider..., as a general proposition, that the use of Special Advocates makes it "possible... to ensure that those detained can achieve justice." Nor should it be thought that, by continuing in our positions as Special Advocates, we are impliedly warranting the fairness or value of the SIAC appeal process.[12]

It may prove to be unfortunate for claimants in the shadow of *Roberts* that Cranston J did not take heed of Mr Ruck Keene's caution when he opined that the appointment of an SA would be 'a highly undesirable situation',[13] when (non-) disclosure hangs in the balance.

Justifying Non-Disclosure

The justification for non-disclosure of medical records derives from the Data Protection Directive 5/46/EC, whose language was largely adopted in the 1998 legislation. Drawing on these provisions, Cranston J highlighted the exemptions set out in Part IV of the 1998 Act, and in particular the powers of the Secretary of State to make Orders which authorise non-disclosure of personal data in matters related to the health of the data subject.[14] One such exemption described by the judge is contained within Article 5 of the Data Protection (Subject

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[11] *R v H* [2004] UKHL 3. At [22]. In the civil context, see *R (on the application of Roberts) v Parole Board* [2005] UKHL 45 at [144], in which Lord Carswell expressed the same opinion.

[12] Above n 10 at [40].

[13] At [20].

[14] At [6].

Access Modification) (Health) Order 2000 (the Health Order),[15] which states that personal data are exempt from s 7 of the DPA where disclosure is 'likely to cause serious harm to the physical or mental condition of the data subject or any other person'. Applying the judgment of Munby J in *R (on the application of Lord) v Secretary of State for the Home Department*, Cranston J stated that the term 'likely' '. . .connotes a degree of probability where there is a very significant weighty chance of prejudice to the identified public interest'.[16] In his opinion, whether disclosure is 'likely' to prejudice one of the public interests is a 'factual inquiry', taking into account matters such as 'the personality of the applicant, his past history, the care regime to which he is subject and so on'.[17]

Roberts's contention was that the defendant had not properly identified a reason for non-disclosure, and so questioned whether it was necessary and proportionate to the unidentified public interest to prevent disclosure of the medical report.[18] However, pace 'clear and compelling reasons based on cogent evidence' provided by the defendant in closed court, Cranston J chose not to release the medical report. He was also 'persuaded' that the exemption relied upon—which may or may not have been the Health Order—should not be revealed, for reasons detailed in the closed judgment.[19] In his view, there was no question that the claimant would receive a fair trial; again, Roberts could rely on his own independent psychological report and thereby challenge the report by B. The judge appeared unconcerned that the report by A was nevertheless valuable to the claimant, in so far as it would enable Roberts's legal representatives to consider the report and prepare its best case before the forthcoming MHRT.

Non-Disclosure to Prevent Serious Harm to the Claimant?

In his open judgment, Cranston J elaborated on the scope of Article 5 of the Health Order, stating that '[i]n the context of mental health, it could be self harm or harm to others'.[20] Since the report was said to contain largely Roberts' own account of his history, if indeed the Health Order was the exemption relied upon in closed judgment, it must be said that non-disclosure for the protection of Roberts' mental health is counter-intuitive; after all, psychologist A was of the opinion that the claimant 'would benefit from seeing the report', and should be allowed to see it.[21]

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[15] SI 2000 No 413.
[16] [2003] EWHC 2073 (Admin), at [100].
[17] At [9].
[18] At [16].
[19] At [23].
[20] At [9].
[21] At [17].

Of course, the claimant suffers from mental health conditions that may impact periodically on his capacity.[22] At the time of the report's preparation, for instance, Roberts might have divulged information which the responsible clinician later believed was not in his best interests to see.[23] However, the Mental Capacity Act 2005 would have had no application given the claimant had not been found to lack capacity. Non-disclosure on this basis of his mental health would therefore have been an 'unjustified assumption' about the patient's incapacity;[24] and the defendant NHS Trust would presumably have acted negligently for failing to prove incapacity.[25]

Bearing in mind that Roberts sought unquantified damages for 'distress and damage' consequent upon non-disclosure, one might argue that the greater risk of harm lay in the *failure* to provide a vulnerable patient—whose ability to self-determine might occasionally be compromised by their mental illness—with personal information. This begs the question: to what extent can patients in a position similar to Roberts self-determine in the face of medical power?

Roberts: A Discourse of Psychiatric Power

At Rampton, as is the case in secure units of lesser security, relationships between staff and patients are typically terse; forging and maintaining therapeutic relationships is fraught with difficulty. Confidentiality in the NHS has often been seen as one means of ensuring trust between patients and clinical staff, and promoting an environment conducive to effective treatment.[26] When confidentiality is breached, there is a risk that the quality of treatment will suffer, either due to the therapeutic relationship suffering from a breakdown in trust, or through the patient's unwillingness to provide further personal information that would furnish the most appropriate treatment plan.

One point of view is that the establishment of expert opinion for a specified purpose —*viz*. the provision of a medical report by A—does not have the effect of creating a therapeutic relationship.[27] Another, preferable, view is that the disrupted relationship between Roberts and psychologist A reinforces the binary nature of the hospital, in which there is, in Goffman's words, 'a basic split between a large managed

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[22] Within the meaning of the Mental Capacity Act 2005 s 2(1).

[23] Hence the use of the phrase 'own account of his history': at [17].

[24] Mental Capacity Act 2005 s 4(1)(b).

[25] S 5(3) excludes a defendant from civil liability for damage caused in relation to a negligent act.

[26] Department of Health, *Confidentiality: NHS Code of Practice* (Department of Health, London 2003), 10.

[27] Note, however, that Roberts was on good terms with the psychologist who wrote the report.

group. . .and a small supervisory staff'.[28] The implication is that refusing to provide personal information, and give reasons, pertains to a power imbalance that exists between staff and patients, borne of institutionalisation.

Goffman argues that the psychiatric hospital is an example of a repressive 'total institution' in which activities are tightly scheduled and brought together into 'a single rational plan purportedly designed to fulfil the official aims of the institution'[29]—in the present case, improving mental health and securing public protection. Life within the total institution is said to compromise one's ability to self-determine. He proffers the example of restricting of the 'passage of information' between doctor and patient, which might be on a range of diverse matters including 'decisions taken regarding their fate'.[30]

While Goffman is content with prescribing the psychiatric institution as repressive *per se*, Foucault's conception of the psy system suggests that power is not merely repressive but also productive in its effects. In his view, individual freedom is synonymic with one's ability within any power relationship, and this includes the doctor–patient coupling, to employ 'tactics' or 'strategy'. The fact that Clive Roberts took his case to the courts is evidence of his ability to self-determine in the face of psychiatric 'power'—that the court chose not to exercise its discretion under s 7(9) of the 1998 Act to order disclosure does not change this. That psy-patients have the capacity to self-determine, however, does not make Roberts necessarily easier to justify on its facts; the case reminds us of how little service users are successful in court.

If one does assume, for the moment, that the Court's decision was not a consequence of statute, that the DPA provides no more than a gateway for the tactical innovation of different actors—the doctor, in choosing not to disclose and give reasons, and Roberts, who used it to invite redress in court—one is left with little more than failed strategy on the part of the claimant. The effect non-disclosure will have on Roberts' response to treatment has already been mooted. Also worth considering is the adverse impact this could have on convincing an MHRT of his suitability for a step-down to medium- or low-secure care, with a view to potential release. Roberts is already 69 years of age.

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[28] E Goffman, 'On the Characteristics of Total Institutions', in *Essays on the Social Situation of Mental Patients and other Inmates* (Penguin Books, London 1961), 18.

[29] Goffman, above n 28, 15–17.

[30] Goffman, above n 28, at [19]. Whether the idea of a 'total' institution is relevant to modern special hospitals is questionable; mitigating factors which make the institution more 'permeable' include plain dress and the secret use of recreational drugs. See A Quirk, P Lelliot and C Seale, 'The Permeable Institution: An Ethnographic Study of Three Acute Psychiatric Wards in London' (2006) 63 Social Science and Medicine 2107–2111.

The decision is made more unsatisfactory by the fact the claimant and his legal team were prevented from posing questions to the NHS Trust on its reasons for non-disclosure.[31] This has the quasi-effect of lowering the burden of civil proof which the defendant must achieve to justify non-disclosure. For those concerned that the courts are unduly deferent to medical authorities, the facts of Roberts will make for disappointing reading. How to respond?

Foucault contends that the 'de-institutionalising' of power relations (one might cite the taking of the NHS Trust to court) allows one to see the 'permeability' of discourse to the external factors that shaped it.[32] One obvious factor that ought to modify the more contentious practices of psy-discourse in a democratic society is law. Here, even Foucault, ordinarily keen to denounce the central role of juridical discourse in shaping the operation of power relations in society,[33] must concede:

> When today one wants to object in some way to the disciplines and all of the effects of power and knowledge that are linked to them, what is it that one does, concretely, in real life...if not precisely appeal to this canon of rights.[34]

Perhaps the most lamentable aspect of the decision in *Roberts* is that his appeal to the strictures of the DPA shows that patient rights may still be subverted by a sea of medical power and judicial deference. And, though Cranston J might have spoken of his 'very serious concerns and unusual circumstances' in respect of the Trust's actions,[35] there is still a nagging suspicion that for all the seriousness of his concerns, he has done little to make claimant's position of subjugation in the mental health courts anything but 'unusual'. How very un-Foucauldian.

Conclusion: Privacy or Transparency?

It is not a simple task to reconcile the judgment in Roberts with substantive and procedural rights. Rule 39.2(3)(c) of the Civil Procedure Rules 1997 states that a hearing, or any part of it, may be conducted in private,

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[31] In their words, they were 'working in a vacuum': at [17].

[32] M Foucault, M Senellart (ed) and G Burchell (tr), *Security, Territory, Population: Lectures at the College de France, 1977–78*, M (Palgrave Macmillan, Basingstoke 2007), 119, footnote of a manuscript not delivered during the lecture, presumably due to illness on the day.

[33] See, for instance, M Foucault,'Truth and Power', in M Foucault, *Power/Knowledge: Selected Interviews and Other Writings, 1972–1977* (Harvester, London 1980), 121; M Foucault and R Hurley (tr), *The History of Sexuality, Vol. 1: An Introduction* (Penguin, Harmondsworth 1981), 85.

[34] M Foucault, 'Two Lectures' in *Power/Knowledge: Selected Interviews and other Writings*, at n 33 above, p. 107–08.

[35] At [31].

if it 'involves confidential information. . .and publicity would damage that confidentiality'. In reaching this decision, the judge will take into account the requirements of Article 6(1) of the Convention (right to a fair and public hearing).[36] Moreover, 'the decision as to whether to hold a hearing in public or in private must be made by the judge conducting the hearing having regard to any *representations* which may have been made to him' [my emphasis].[37]

In respect of this latter requirement, the judge's decision to hear the exemption relied upon by the defendant in private is baffling. Cranston J suggested that '[f]or the reasons given in Closed Judgment the circumstances here were highly unusual';[38] yet, one would assume that the more unusual the exemption, the stronger the justification for disclosing it. As it was, Cranston J decided to provide a closed judgment on the sole basis that the NHS Trust had been unwilling up until trial to provide Roberts' solicitors with the exemption it was relying on. In effect, the appropriateness of the exemption was not known *until* the decision to hear the defendant's reasons in private had been reached. Consequently, the justification to 'go private' was borne of the judge's confidence in the defendant's reasons for non-disclosure *a priori*. In an era which is supposed to be increasing the 'transparency' of the administration of justice,[39] this makes the reasoning in *Roberts* dubious.

It does not have to follow that observers of the case need agree with the outcome of an appeal, in Foucault's words, to 'cannon of rights'; for *Roberts* warns us, above all else, that 'rights' must be given a chance to speak for themselves in a transparent court, if only to temper fears that medical power can subvert natural justice. Whether Foucault—being keen to extricate himself from the humanistic movement—would go as far as to order a rethink of the law when decisions like this are reached is another matter. What he would not abide by, however, for good reason, is the exclusion of those with mental health conditions from participating in court proceedings, absent sufficient reasons:

> the important question. . .is not whether a culture without restraints is possible or even desirable but whether the system of constraint in which a society functions leaves individuals the liberty to transform the system. Obviously constraints of any kind are going to be intolerable to certain segments of society. But a system of constraint

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[36] In accordance with para. 1.4A of the Practice Direction to Part 39 of the CPR.

[37] Para. 1.4 of the Practice Direction to Part 39 of the CPR.

[38] At [32].

[39] See for instance Department for Constitutional Affairs, *Confidence and Confidentiality: Improving Transparency and Privacy in Family Courts*, Cm 6886 (TSO, London 2006).

becomes truly intolerable when the individuals who are affected by it don't have the means of modifying it.[40]

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[40] M. Foucault, *Politics, Philosophy, Culture: Interviews and Other Writings, 1977–1984* (Routledge, New York 1988), 294.