

Medical Law

Topic 1 (of 10), Consent. **Lecture 2** (of 4):

Capacity to Consent to Medical Treatment

Aim:

To outline how English law determines whether a person – adult or minor – has the mental capacity to make his/her own decisions to accept or reject medical treatment.

Objectives:

After careful study of this topic you should be able to:

1. Explain the general, but rebuttable, rule relating to the capacity of an adult;
2. Explain how the capacity of a minor may be determined and discuss the cases that 'make a nonsense of *Gillick*' (per *Brazier* and *Cave*);
3. Discuss the provisions of the Mental Capacity Act 2005 relating to the determination of a person's capacity.

The Nature of Capacity

Respect for the principle of autonomy is at the basis of consent. In essence, an autonomous person is a person of 'adult years and sound mind,' (*Schloendorff*, as approved by the House of Lords in *Bland*). That an autonomous person can act on the basis of his own thoughts and deliberations, subject to not infringing the autonomy of another person, means that, in relation to treatment decisions, such a person (i.e., a patient) has the ultimate power to accept or, controversially, in the case of adults, only, reject the proposed treatment(s). In law, this legally recognized ultimate decision-making authority of the patient is expressed as the person having the **capacity** for self-determination ('First person capacity'). In essence, autonomy and / or the right to self-determination are the moral equivalents of what the law recognises as capacity.

Whereas it remains important to discuss the nature of capacity, comparisons of the theoretical approaches to the possible determination of capacity with the actual determination at common law now have to be seen primarily in historical context, as academic debate has yielded to the primacy of statutory guidance on the assessment of capacity via provisions of the **Family Law Reform Act 1969** (for minors) and the **Mental Capacity Act 2005**, for the over-16s, only.

(I) The Meaning of Capacity

Capacity is the legal recognition of a person's autonomy. For well over 160 years there was a common law presumption that an adult was autonomous: i.e., (s)he had the right of self-determination / had the capacity to consent to treatment. The presumption appeared to derive from the M'Naughten rules (1843) where it was held that, as a general rule, an adult was presumed to have the capacity to be responsible for his criminal actions. For medical interventions, capacity became a status conferred on one person by another who was expressly or impliedly permitted by law to confer that status - a doctor in the doctor/patient relationship, for example, especially when the patient was a minor.

If there was a need to determine whether a patient had the capacity to make a personal health-care decision, it appeared that (s)he must possess:

- the ability to receive and give information. This ability would be assessed solely in relation to proposed treatment. The assessment focused on the patient's emotional state [See: Re T (1992)] as well as his perceived knowledge of the options; and
- The ability to compare the potential impact of accepting or refusing treatment; and
- The ability to make reasonably consistent choices.

A patient's ability to receive information and compare alternatives generally varies with the nature of the proposed treatment so ***the test for capacity varied from one context to another***. This '*functional*' test focused on the variation in the degree of understanding required for a patient to be considered sufficiently competent and to have the capacity to consent to treatment. The point was illustrated in a decided case where the requisite degree of understanding on which to base capacity was said to be present and sufficient for a man to marry but not to make a new will only hours after the marriage ceremony: In the Estate of Park [1954] P 112.

It was of paramount importance, therefore, that a test for capacity was set at a standard at which an acceptable balance between the preservation of individual autonomy, on the one hand, and the provision of needed medical care, on the other, was maintained.

Whilst the 'starting point' for a discussion of a patient's capacity now starts with the assumption that: "a person must be assumed to have capacity *unless* it is established that he lacks capacity", (**s.1(2) MCA 2005**), a review of the possible theoretical approaches to capacity will help inform the debate surrounding its determination.

(II) Possible (Theoretical) Approaches to the Establishment of Capacity at Common Law

At least four different approaches have been suggested as *possible* theoretical means of establishing capacity, viz;

- Evidencing a choice (or ‘expression of preference’ test);
- The Outcome Approach;
- Status;
- Understanding (or the ‘functional’ approach).

{**N.B.:** The 1995 Law Commission Report, No.231, on *Mental Incapacity*, acknowledged (b) – (d), below, as the three broad approaches to capacity. They adopted and recommended (d).}

(a) Evidencing a Choice

This basic test provides that a patient has decision-making capacity if he merely evidences a preference for or against treatment. Only a patient who does not evidence a preference either verbally or through his or her behaviour is considered to lack capacity. This test provides no assurance that a patient understands his expressed preference to consent or to refuse consent to treatment; but a supposed advantage is that it guards against excessive paternalism.

(b) Reasonable Outcome of Choice.

Under this test, a patient is regarded as lacking capacity if he fails to make a decision that is ‘in line’ with conventional wisdom as to what constitutes a ‘proper’ health care decision. On this basis, treatment could then be imposed as being necessary. But as *Roth et al* point out: ‘The benefits and costs of this test are that social goals and individual health are promoted at considerable expense to personal autonomy.’ *Kennedy & Grubb* also are of the opinion that this is an invalid approach to determining capacity: that ‘if it has any significance at all, [it] can only serve as a possible criterion for establishing capacity’. i.e., it is, at most, only one of several factors. (And note their further comment below.)

Judicial support for the autonomous patient’s expressed opinion being given preference over the ‘reasonable outcome of choice’ approach is found in the *New Zealand* case of *Smith v Auckland Hospital Board* (1965) where *Gresson J* said that:

“An individual patient must, in my view, always retain the right to decline operative investigation or treatment however unreasonable or foolish this may appear in the eyes of his medical advisors.”

Kennedy & Grubb point out that whereas:

“The issue of capacity did not arise directly in [Smith’s] case ... *Gresson J’s* remark appears to be authority for the proposition that ***capacity is not to be doubted simply on the ground that the decision is unreasonable in the eyes of others.***”

Further support for this proposition was given by *Prowse J* in the *Canadian* case of *Hopp v Lepp* (1979) where he said:

“Each patient is entitled to make his own decision even though it may not accord with the decision knowledgeable members of the profession would make. ***The patient has a right to be wrong.***”

(c) Status.

The basis of this approach is that capacity is conferred on someone belonging to a particular group and lack of capacity is associated with those outside the group. **The age of minority** is a *prima facie* example of capacity being conferred on someone by way of the status approach. The **Family Law Reform Act 1969** lowered the age of majority from 21 to 18. On a literal interpretation of the status approach to autonomy, then, it might appear that only those 18 and over have the capacity to consent to treatment or refuse it. However:

(i) As **Skegg** notes:

“Medical procedures are not in a different category from other bodily touchings. If minors are incapable by reason of their age alone of consenting to medical procedures, it would follow that they were incapable of consenting to other touchings. ... [including] not be[ing] able to give a legally effective consent to a haircut. There is no reason to believe that this is so ...”

(ii) The status approach based on the age of majority was rejected by **Ady J** in: *Johnston v Wellesley Hospital* (1970). He said he couldn't find any case law to support '... that a person under the age of majority was legally incapable of consenting to medical treatment.'

(iii) **s.8 (1) FLRA 1969** confirmed the *irrelevance* of the age of majority determining capacity to consent to medical treatment. **s.8(1)** provides that:

The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has ... given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.

Age of consent lowered - but still a status approach to determining capacity?

An unqualified reading of s.8(1) would apparently indicate that the age of 16 had simply replaced the age of 18 as the age of majority for 'surgical, medical or dental treatment.' However, a fixed age limit was criticised by Lord **Scarman** in *Gillick v West Norfolk and Wisbech Area Health Authority* (1985) where he said:

“a fixed age limit of 16 ... brings with it an inflexibility and a rigidity which in some branches of the law can obstruct justice, impede the law's development and stamp on the law the mark of obsolescence where what is needed is the capacity for development.”

That s.8 (1) does **not** prevent the possibility of minors *under* the age of sixteen from giving a legally effective consent to medical treatment in appropriate circumstances is confirmed by **s.8(3) FLRA 1969** which provides that: 'Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.' In essence, then, **s.8(3)** left open the possibility of a minor consenting to treatment on the basis of his/her common law capacity; and the determination of a minor's capacity was based on *understanding*.

(d) Understanding

Problems with 'understanding' as an approach to capacity

Two problems, in particular, with this test are:

- (i) deciding on what level of understanding there must be in order that a patient may be regarded as having capacity to consent; and
- (ii) the application of this test depends on unobservable and inferential mental processes rather than on concrete and observable elements of behaviour.

What level of understanding is required for a person to have capacity to consent?

Before a doctor could make a decision to recognise a patient's autonomy, it would appear that he has to decide which of the following provides *the* appropriate criterion in his assessment:

- (a) That the patient **does** in fact understand what is involved; or
- (b) That the patient is *capable* generally of understanding (though it may later emerge that the patient did not in fact understand the issues in the instance in question); or
- (c) That any *reasonable patient* is capable of understanding or would have understood the issue(s)?

Comments

(c) is rejected as it fails to focus on the particular patient: it is senseless suggesting that it is *the* patient who must be capable of understanding the issues but then approving a test which does **not** require *that particular patient* to understand, only some notional reasonable patient having to.

(a) Places an onerous burden on a doctor and is also rejected.

(b) [The capability of understanding] Appears to be the only reasonably practicable standard.

The Capability of Understanding.

It is the *capability* of understanding, or the ability to understand the broad terms of the nature of the treatment intended, that is significant: neither rational thought nor outcome is a necessary prerequisite for establishing capacity. Indeed:

“ ... the patient's right of choice exists whether the reasons for making that choice are rational, irrational, unknown or even non-existent.” (*per Lord Donaldson in Re I* (1992)).

Thus, unwise choices may be permitted and respected since what matters in this test is that the patient is able to comprehend the elements that are presumed by law to be a part of treatment decision making (i.e. the patient must understand the ‘*broad terms of the nature of the procedure which is intended,*’ per Chatterton v Gerson (1981)).

[See now **s.1(4) MCA 2005** which states that: ‘A person is not to be treated as unable to make a decision merely because he makes an unwise decision’.]

A patient’s capacity for understanding may be tested by asking him a series of questions relating to risks, benefits and alternatives to treatment, providing further information where necessary, and then seeking defects in comprehension. **Skegg** sums up by noting that: “Capacity to give a legally effective consent depends upon capacity to understand and come to a decision on what is involved, and the capacity to communicate that decision.” This was further elaborated by **Lord Donaldson** in Re T (Adult: Refusal of Medical Treatment) (1992) where he said that:

“What matters is that doctors should consider whether at that time [the patient] had a capacity which was commensurate with the gravity of the decision which he [the patient] purported to make. The more serious the decision, the greater the **capacity** required.”

[Q. In the second sentence of **Lord Donaldson’s** dictum, *supra*, has he confused capacity with competence? It would appear so, given that in the later case of Re MB (An Adult: Refusal of Medical Treatment) [1997] 8 Med LR 217 @224, **Butler-Sloss P** said:

“The graver the consequences of a decision, the commensurately greater the level of competence is required to take the decision.”]

What constitutes ‘understanding’ and ‘effective consent’ will be matters of fact in each particular case, i.e. any notion of capacity is individual-orientated. This is well-illustrated by contrasting two Commonwealth cases. In an unreported New Zealand case of 1966 a doctor described a suspected drunken driver who he examined as: ‘pretty far gone.’ The driver, however, maintained he was sober. To settle the point ‘one way or the other’ the doctor suggested taking a blood sample to which the driver agreed. The test revealed a blood alcohol level of more than double the statutory maximum and the driver was subsequently convicted of the drink-driving offence. The driver then brought an action against the doctor alleging that he had been too drunk to give a legally effective consent. **HELD:** At the time the sample was taken, the driver was incapable of consenting: he was successful in his claim for damages.

In the similar Canadian case of R v Ford (1948), however, the judge was satisfied that the man: ‘... was in no way bereft of his powers of decision and that he knew quite well what he was doing when he came to the decision to give the sample.’

The essence of each case is that the doctors should consider whether at the relevant time the patient had a capacity which was commensurate with the gravity of the decision which he purported to make or whether his (the patient's) capacity was so reduced by other factors that he does not sufficiently understand the nature, purpose and effects of the proffered treatment (to reiterate: this is often referred to as the functional test). This was the approach taken by **Thorpe J** in *Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290, the case in which a 68-year-old paranoid schizophrenic succeeded in obtaining an injunction restraining the health authorities from amputating his gangrenous foot then *or at any time in the future*. C succeeded because the presumption of self-determination had not been displaced and the judge was of the opinion that C had satisfied a three-stage process of decision-making, a process that now, in essence, underpins the approach to capacity, viz;

- (i) he had comprehended and retained the treatment information;
- (ii) he had believed that information; and
- (iii) he weighed the information 'in the balance to arrive at a choice'.

[See also: *Re MB* [1997] 2 FCR 541]

{N.B.: The *Re C* test is at the basis of the test for capacity under *s.3(1) Mental Capacity Act 2005* (see *infra*)}

Minors Demonstrating Capability of Understanding.

In relation to minors, the majority opinion in *Gillick* confirmed that capacity is based on capability of understanding.

Gillick v West Norfolk and Wisbech AHA [1986] AC 112

Mrs Victoria Gillick objected to a 1981 DHSS circular which stated that in certain circumstances a doctor could prescribe contraceptive advice and treatment to a girl under 16 without the knowledge or consent of her parents: i.e. (in effect) Mrs Gillick was contending that girls under the age of 16 did not have capacity to consent to contraceptive treatment. In the High Court she failed to get a declaration that the DHSS guidelines were unlawful; she succeeded in gaining a unanimous decision in her favour in the Court of Appeal; but then failed by 3 - 2 to have this decision upheld by the House of Lords.

Lords Fraser, Scarman and **Bridge** formed the majority opinion, and although **Lord Templeman** (who gave a dissenting opinion) 'agreed' with Lords Fraser and Scarman on the issue of understanding, their Lordships failed to produce a clear rationale of what constitutes 'understanding.' **Lord Fraser's** opinion was that a factor on which a doctor was to be satisfied was: (i) 'that the girl (although under 16 years of age) will understand his advice.' But, overall:

“The solution depends on a judgment of what is best for the welfare of the particular child ... [and] there may be circumstances in which a doctor is a better judge of the medical advice and treatment which will conduce to a girl’s welfare than her parents. ... [which may include situations where] there is no realistic prospect of her abstaining from intercourse. ... [in which case it is] in the girl’s best interest, to give her contraceptive advice and treatment if necessary without the consent or even knowledge of her parents. The medical profession have in modern times come to be entrusted with very wide discretionary powers going beyond the strict limits of clinical judgment and, in my opinion, there is nothing strange about entrusting them with this further responsibility which they alone are in a position to discharge satisfactorily. [So] provided the patient, whether a boy or a girl, is capable of understanding what is proposed ... I see no good reason for holding that he or she lacks the capacity to express (his or her wishes) validly and effectively and to authorise the medical man ... to give the treatment.”

Thus, **Lord Fraser** accorded the medical profession a great deal of discretion in such circumstances. **Lord Scarman**, on the other hand, put a far more stringent obligation on the doctor. He said:

“... there is much that has to be understood by a girl under the age of sixteen if she is to have legal capacity to consent to such treatment. It is not enough that she should understand the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved. There are moral and family questions ... and ... risks to health of sexual intercourse at her age ... it follows that a doctor will have to satisfy himself that she is able to appraise these factors before he can safely proceed on the basis that she has at law capacity to consent to contraceptive treatment. [The doctor should] not prescribe contraceptive treatment unless he is satisfied that her circumstances are such that he ought to proceed without parental knowledge and consent.”

Lord Templeman’s view is contained in the sentence where he said:

“The effect of the consent of the infant depends on the nature of the treatment and the age and understanding of the infant.”

{**N.B.:** (1) The common law ‘capability of understanding’ test (the functional approach) continues to apply: the **Mental Capacity Act 2005** does **NOT** apply to minors under the age of 16. (2) Note the application of Lord Fraser’s guidelines in Axon’s case [2006] QB 539}

The Law Relating to Minors Refusing Consent: an Affront to the Gillick Principle?

From the time the Lords delivered their opinions (October 1985) until July 1991, the position relating to capacity of minors appeared to be relatively straightforward, viz;

- (i) a child who was mature enough and intelligent enough to understand the broad terms the nature of the proposed treatment could consent to it;
- (ii) “As a matter of law the parental right to *determine* whether or not their minor child below the age of 16 will have medical treatment *terminates* if and when the child achieves sufficient understanding and intelligence to enable him or her to understand fully what is proposed.” (per **Lord Scarman** in *Gillick*).
- (iii) High Court (i.e. first instance) decisions in *Re E* (1990) and *Re R* (1991) held that the principle in *Gillick* applied to *refusal of treatment* as well as consent to it.

That no common ratio was discernible in *Gillick* (because of the different opinions as to what constituted understanding); or that it wasn't clear whether *Gillick competence* applied to all forms of medical treatment or contraceptive treatment only, did not appear unduly to complicate matters. However, it is, perhaps, important to note that *Gillick* was concerned with:

- (i) the staged development of a ‘normal’ child; who ...
- (ii) *consented* to treatment; and with the issue of competing capacities being between ...
- (iii) the minor and its parents.

It remained to be seen whether the *Gillick* principle would apply to:

- (i) a minor who suffered from a fluctuating mental disorder (e.g. cyclical phases of paranoia and psychosis alternating with lucid intervals); who ...
- (ii) *refused* treatment; and who ...
- (iii) was a ward of court where the competing issues of capacity (or its determination?) were between the court and the minor in wardship.

In essence, these were the issues to be decided by the Court of Appeal in *Re R* (1991). In ‘reverse order’ the Court of Appeal decided that:

- (iii) Since the Court's inherent jurisdiction in wardship derived from the Crown's duty to protect its subjects, its powers were not only greater than those of the ward's natural parents but, in theory anyway, they were *limitless*. So, for example, if the ward or the ward's parents disagreed with the Court, the Court could *overrule and authorize*: ...
- (ii) the treatment which was in the ward's best interests *even if the minor in wardship had had the capacity to refuse treatment* (cf. Lord Scarman's: ‘... *parental right* to determine ... medical treatment *terminates* ...’ in *Gillick*); and, perhaps not surprisingly; ...
- (i) a minor suffering from a fluctuating mental disorder could **not** be regarded as having achieved *Gillick* competence.

However, **Lord Donaldson MR's** judgment in the Court of Appeal decision in *Re R* (1991) led to the publication of a great deal of critical comment / confusion as to whether ‘*Gillick* rights’ were under threat. Commentators such as **Professor Ian Kennedy**, **Gillian Douglas**, **Jenny Unwin**, **Jon Montgomery** and **Professor Michael Freeman** were unanimous in condemning Lord Donaldson's judgment in respect of parental powers of consent being *an acceptable alternative* when their ‘autonomous’ minor refused treatment.

Re R [1991] 3 WLR 592

R, a 15 year old girl, had been taken into the care of the local authority after a fight with her father. Her deteriorating mental health led the local authority to make an application for her admission to hospital under provisions of the **Mental Health Act 1983**. She was then transferred to a specialist adolescent psychiatric unit where the consultant wished to administer to her anti-psychotic medication by injection. Whereas the local authority at first consented to this, they withdrew the consent after R had made a 3 hour telephone call to a social worker in which she sounded lucid and rational. However, the unit was not prepared to keep R unless it was given authority to administer the medication. The local authority then initiated wardship proceedings and sought permission of the court for the doctors at the unit to administer the medication with or without R's consent. At first instance, the judge granted the application for R to be made a ward of court and for her to be given the medication on the basis that she was not competent to refuse treatment. He added that if she was a competent minor, then the wardship jurisdiction would not entitle him to overrule her refusal. The Official Solicitor appealed and requested guidance on the determination of whether R was a competent minor in the Gillick sense and if so: (i) whether the parent of a competent minor had the power to override the minor's decision either by granting consent when the minor had refused it, or vice versa; and (ii) whether the court had the power to override the decision of a competent minor who was a ward.

HELD: The staged development of a normal child does not 'fluctuate upon a day to day or week to week basis' (per **Lord Donaldson**). No minor who exhibits fluctuating competence i.e. having the capability of understanding to meet the *Gillick* criteria one day but not the next can be regarded as *Gillick competent*. With regard to the two specific questions:

- (i) Parents **do** retain their capacity to authorise treatment when their Gillick competent minor child objects (i.e., 'proxy capacity'). This is due to consent being:

'... a key which unlocks a door. Furthermore, whilst in the case of an adult of full capacity there will usually be one key holder, namely the patient, in the ordinary family unit where a young child is the patient there will be two key holders, namely the parents, with a several as well as a joint right to turn the key and unlock the door.'

In other words, parental consent would provide the doctor who administered treatment to a non-consenting minor with a defence to civil and criminal actions. As to **Lord Scarman's** reference in *Gillick* to 'the parental right to *determine* whether or not their minor child below the age of 16 will have medical treatment *terminates* if and when the child achieves sufficient understanding and intelligence ...,' **Lord Donaldson MR** said that the right to determine (i.e. the power both to authorise and veto treatment) was wider than the right to consent and that:

"The parents can only have a right of *determination* if either the child has no right to consent, i.e. is not a key holder, or the parents hold the master key which could nullify the child's consent."

So, in the case of a Gillick competent minor who consents to treatment Lord Donaldson went on to conclude that this consent would make the treatment lawful even if the parents did not consent (i.e. in this case it would be determinative) whereas, in the reverse situation, i.e. the minor refusing treatment but the parents consenting to it, then it would be their consent which would enable the treatment to be administered lawfully. Consent gives *permission* for treatment to be administered: it does not place a registered medical practitioner under an *obligation* to administer it.

(ii) Since the courts powers in wardship are not derived from parental responsibility and, in theory, they are limitless, then the courts could override the refusal of a Gillick competent minor and consent to treatment if they thought it was in the minor's best interests.

Although academic comment on the decision in *Re R* is almost universally hostile, *Re R* was followed in *Re W* (1992).

Re W (Consent to treatment) [1992] 4 All ER 627

16 year old W was an anorexic in the care of the local authority. She refused to consent to treatment for her condition and was made a ward of court. At first instance, Thorpe J found that although W had sufficient understanding to make a decision, nevertheless, the court had inherent jurisdiction to order her to be taken to hospital and to be treated against her wishes if necessary. On appeal, **Lord Donaldson MR** reviewed the common law (Gillick & *Re R*) and the provisions of **s.8 FLRA 1969**. He considered that "religious or other beliefs which bar any medical treatment or treatment of particular kinds are irrational, but that does not make minors who hold those beliefs any the less 'Gillick competent'". However:

no minor of whatever age has power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor and a fortiori a consent by the court.

Furthermore, s.8 of the 1969 Act, which gives minors aged 16 and over the right to consent to surgical, medical or dental treatment and which cannot be overridden by those with parental responsibility, can be overridden by the court. Significantly, Lord Donaldson also observed a feature of anorexia nervosa being that it is capable of destroying the ability to make an informed choice, i.e., it creates a compulsion to refuse treatment or only to accept treatment which is likely to be ineffective.

HELD: Since "*Good parenting involved giving minors as much rope as they could handle without an unacceptable risk that they would hang themselves*" and s.8 of the Family Law Reform Act 1969 did not confer complete autonomy on minors over the age of 16 with regard to their medical treatment, the court would exercise its inherent jurisdiction and authorise the treatment of W. Moreover, **Lord Donaldson** preferred to compare consent with a flak-jacket rather than continue with the key-holder analogy put forward in *Re R*, given that a key could just as readily 'lock' as 'unlock'. He expressed his new preference by saying:

I now prefer the analogy of the legal flack-jacket which protects from claims by the litigious whether [the doctor] acquires it from the patient who may be a minor over the age of 16, or a *Gillick competent* child under that age or from another person having parental responsibilities which include a right to consent to treatment of the minor. Anyone who gives him a flack-jacket (i.e., consent) may take it back, but the doctor only needs one and so long as he continues to have one he has the legal right to proceed.

Post-*Re R* & *Re W*, cases have been consistent in promoting the judicial policy of labeling minors **not** *Gillick* competent where a finding to the contrary would lead to the death of the minor who was refusing life-saving treatment: *Re E* (1993); *Re S* (1994); *Re L* (1998); and *Re M* (1999). Whereas this blanket uniformity may be welcomed as upholding the principle of the sanctity of life, it is a policy that becomes questionable if it detracts from the principle of the capacity of a minor being based solely on the capability of understanding the broad nature of the treatment intended; or, as some would bluntly assert, “*Re R* and *Re W* make a nonsense of *Gillick*”¹.

Adults Refusing to Consent to Treatment

The controversy surrounding compulsory treatment has not been confined to *Gillick* competent minors. Indeed, even more criticism was directed at two cases decided in July and October 1992, and two cases decided in the summer of 1996, which involved overriding the express refusal to consent to treatment given by adults (i.e. those who have reached the age of majority) of unimpaired capacity. The decided cases referred to are *Re T* (*the refusal of a blood transfusion case*) & *Re S* (*the refusal of a pregnant woman in labour to undergo a caesarean section case*). [N.B. In *Re T* (1992), where a 20 year old woman said that she would refuse a blood transfusion, it was said that it *wasn't* her capacity which was in question: permission to give the transfusion was granted because **T** had been misinformed as to the availability and effectiveness of alternative procedures, a consequence being that her refusal did not extend to a transfusion in the extreme position which subsequently arose. The judge's order was affirmed by the Court of Appeal who added that there was evidence that T was not in a physical or mental condition which enabled her to reach a decision binding on the medical authorities; though, even if that could be rebutted, the influence of T's mother was such as to vitiate T's decision].

The Perceived Conflict Between the Right of Bodily Integrity of an Autonomous, Pregnant Woman and her Unborn Child.

Re S (1992) *The Times*, 16 October

A 30 year old woman who had been in labour for two days refused to consent to a caesarean section because of her religious beliefs. The operation had been deemed necessary to attempt to save her life and that of the unborn baby.

¹ *Brazier & Cave* (2007), *Medicine, Patients and the Law*, 4/e, p405.

HELD: The President of the Family Division declared that the operation could be performed even though the woman was competent to make her own decisions. The decision was based on the ground that the baby's life might be saved. (The baby died: the mother was still in a serious condition on the day the case was reported, 16/10/92).

The decision in *Re S* attracted enormous criticism from some of the most respected practitioners and academics including **Professor Ian Kennedy, Diana Brahms** and **Alexander McCall Smith**. **Professor Kennedy** expressed the opinion that: 'It is so potentially intrusive as to reduce women back to the status of slaves.' His view, it would appear, has been endorsed by the Court of Appeal in *Re MB* [1997] 2 FLR 426. However, it should be recalled that:

- (i) The presumption of capacity on reaching the age of majority is *rebuttable*;
- (ii) Factors such as pain, drugs, lack of information being supplied to the patient, erroneous assumptions made by the patient, the overbearing will of a spouse or parent can reduce or vitiate the patient's capacity at the time when his/her decision could have grave consequences for him/her or a baby about to be born. (Remember Mrs S was in labour).
- (iii) If the wishes or beliefs of the patient are expressed or recorded at a time when an emergency arises but when there is no doubt about the patient's capacity, then the doctor has no right to override the patient's request: *R v Blaue* (1975)
- (iv) If a competent patient is unconscious and in need of emergency treatment then a doctor can act in what he sees as the patients best interests. However, he can only use this as a defence if he was unaware of the patient's wishes or beliefs which would have prevented him from administering the treatment: *Malette v Shulman* (1990).
- (v) The determination of what action is in the patient's best interests in a case of necessity/emergency is based on the *Bolam* test. Accordingly, if a responsible body of medical practitioners would aim to save the patient's life, and they would try and do so because the patients capacity is in doubt, then not only would the MDU support the doctor taking the action but it is almost inconceivable that a court would rule against him.

[N.B.:

(i) Legal challenges followed declarations authorizing another two 1996 non-consensual caesareans. Indeed, it was reported that: "We now know of five Family Division judges who have done this and there may be many more." [See (1996) *The Times*, 23 September, p6: '**Woman challenges hospital's right to impose Caesarean**']. However, it was said at the time that: "It is unclear on what grounds the rulings will be challenged." [Same article, column 2].

(ii) One of the most significant cases on caesarean sections is now *Re MB* [1997] 2 FLR 426. It must be understood why a declaration that it would be lawful to carry out the caesarean section in this case was granted and what the Court of Appeal said about the right of competent, pregnant women to refuse treatment in circumstances which would put at risk not only their lives but those of the unborn children.]

(In St George's Healthcare NHS Trust v S, (1998) *The Times*, 8th May, The Court of Appeal confirmed the right of a competent, pregnant woman to refuse medical treatment even though in doing so *she and her unborn child might die*. Guidelines as to what to do when a patient whose competence is in doubt refuses consent to medical treatment were given in St George's Healthcare NHS Trust v S (No. 2) (1998) *The Times*, 3rd August. The Court of Appeal stressed that what they issued were merely guidelines and that "where delay itself might cause serious damage to the patient's health or put the patient's life at risk then formulaic compliance with the guidelines would be inappropriate.")

Assessing Capacity under the Mental Capacity Act 2005

Background

The significant issue of establishing the legal basis on which an adult patient *lacking* mental capacity could have medical treatment administered to him – i.e., be in receipt of non-consensual medical treatment - has been addressed by the courts over barely a 20-year period. Indeed, the House of Lords established this basis (which focused on the patient's best interests) only as recently as 1989 in F v West Berkshire Health Authority, reported as: Re F (Mental Patient: Sterilisation) [1990] 2 AC 1. (See Lecture 4 for an analysis).

However, that a patient was detained in hospital under provisions of the **Mental Health Act 1983** did **NOT** necessarily mean that treatment could be imposed on him in his 'best interests'. Whereas certain provisions of Part IV of the MHA 1983 *do* provide for non-consensual medical treatment, Re C [1994] 1 WLR 290 revealed that a patient who was not subject to those provisions and whose mental impairment was such as not to render him incapable of understanding the purpose of the treatment retained the right to reject it.

Not directly linked to the cases above, but following them, came a **Law Commission Report No.231** in 1995 on Mental Incapacity and this addressed all the different needs of those lacking mental capacity, not just their medical needs. Another seemingly unrelated Act, the **Human Rights Act 1998** came into force in 2000.

More than a decade passed from the time the Law Commission published Report No.231 on Mental Incapacity (February 1995) to the time a Mental Capacity Bill received Royal Assent (April 2005). Provisions of the Act deal with, *inter alia*, situations where an individual loses mental capacity at some point during his lifetime and where the incapacitating condition has been present since birth. Certain provisions of the 2005 Act came into force from 1st April 2007 and the Act was fully in force by 1st October 2007. That the Act applies to the over-16s, only, means that issues of capacity of minors remain to be decided at common law.

Certain provisions of the 2005 Act² have already been amended by the **Mental Health Act 2007**. Some provisions had to be amended because a decision of the **European Court of Human Rights**³ found a violation of the rights under **Art.5 ECHR** (given the force of law by the *Human Rights Act 1998*) of a mentally incapacitated man who had been detained in hospital (under powers the House of Lords claimed had been derived from Re F (1989)).

The Mental Capacity Act 2005 (as amended)

The provisions of this Act now provide the 'starting points' if a person's decision-making capacity were to be challenged and the pre-Act case law remains as appropriate and valid interpretations of the codified Act. The challenge to a person's capacity will focus on **ss.2** and **3**, *infra*.

The Act is in three parts, *viz*;

Part 1: Persons who lack capacity;

Part 2: The Court of Protection and the Public Guardian; and

Part 3: Miscellaneous and General.

In essence, this course deals with certain provisions contained in Part 1. Basically, the Act puts on a statutory basis much of the established common law. Provisions of the Act of particular relevance are:

s.1(2) provides that 'a person must be assumed to have capacity unless it is established that he lacks capacity'; {continuation of the common law presumption}.

s.1(3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

s.1(4) states that: 'A person is not to be treated as unable to make a decision merely because he makes an unwise decision'; {see case law, especially Re T, *supra*} and

s.1(5) provides that an act done or decision made on behalf of a person who lacks capacity must be done, or made, in that person's best interests {See Re F, next lecture}.

ss.2 and 3 and a challenge to a patient's decision-making capacity

s.2 provides more detail on people who lack capacity *at a particular time* and sub-section (5) excludes the application of this Act to minors under the age of 16. {Accordingly, s.8(3) Family Law Reform Act 1969 continues to permit decisions relating to a minor's capacity to be decided at common law}.

s.3 refers to 'inability to make decisions' with s.3(1) essentially being a statutory enactment of the three-stage Re C test and s.3(3) being notable for **not** disqualifying a person having fluctuating mental capacity from being able to make decisions.

² Discussion of the Act replacing part of the **Mental Health Act 1983** and the whole of the **Enduring Powers of Attorney Act 1985** is beyond the syllabus for this module.

³ HL v United Kingdom (2004)40 EHRR 761

Accordingly, should a person's capacity be challenged, **s.2(1)** of the Act provides that that person (patient) lacks capacity only if: "at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain".

{**s.2(2)** adds that "it does not matter whether the impairment or disturbance is permanent or temporary"; and **s.2(3)** provides that, inter alia, "A lack of capacity cannot be established merely by reference to (a) a person's age or appearance"}.

This 'first-stage' statement of incapacity in **s.2** is followed by the 'second stage' determinative criteria in **s.3** – particularly **s.3(1)** - that state that a patient will be considered unable to make a decision for himself if he is unable:

- (a) to understand the information relevant to the decision;
- (b) to retain that information;
- (c) to use or weigh that information as part of the process of making the decision; or
- (d) to communicate his decision by any means.

s.4 Here, a detailed account of 'best interests' has been amended by the **Mental Health Act 2007** and **s.5** makes provisions for a person who acts in the best interests of another who lacks mental capacity to avoid legal liability for his actions.

ss.24-26 provide for the validity and applicability of advance directions to refuse treatment that were made by a person who reached the age of 18 and who had the capacity to make them.

A 302-page Code of Practice made under **ss.42** and **43** of the Act was issued in April 2007.

(III) What if a doctor's assessment of capacity proves incorrect?

If a patient suffers injury as a result of a doctor's treatment, an action against him in tort may be possible. The problems to be resolved are:

- (i) has the doctor's mistake been a reasonable one? An affirmative answer might negate liability in negligence if not in battery.
- (ii) has the doctor's mistake been one of fact or opinion? A mistake of fact might not prevent liability in battery as mistake isn't regarded as a defence to an intentional tort. If it is a mistake of opinion, it would appear that the law is uncertain.

(N.B.: when a doctor deemed that a young girl did *not* have the capacity to consent to contraceptive treatment and informed her parents of her request, the GMC took no disciplinary action against him: Miss X v. Dr Brown (1971)).

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Significant Pre-MCA 2005 Act Cases

- Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290.
- Gillick v. West Norfolk and Wisbech A.H.A.* [1986] 1 FLR 224.
- Re R (A Minor)(Wardship: consent to Medical Treatment)* [1991] 3 WLR 592.
- Re W (A Minor)(Medical Treatment)* [1992] 4 All ER 627.
- Re M (child: refusal of medical treatment)* [1999] 2 FLR 1097
- Re MB (Adult: Medical Treatment)* [1997] 2 FLR 426.
- St George's Healthcare NHS Trust* [1998] 3 WLR 936.
- St George's Healthcare NHS Trust (No.2)* [1999] Fam 26.

Statute

Mental Capacity Act 2005 (www.opsi.gov.uk/acts/acts2005/20050009.htm)

Workshop Questions

1. To what extent, if at all, is 'understanding' a satisfactory test of capacity to consent to medical treatment? To what extent, if at all, does the law respect and uphold the right of an individual to refuse medical treatment that the medical profession has deemed to be beneficial to that individual?
2. Under what circumstances, if any, would you agree that the judiciary would be justified in overriding refusal of medical treatment by pregnant women and minors?
3. (a) Critically review the case, and academic criticisms of, *Re R* [1991] 3 WLR 592. **AND**
(b) When, if ever, would you permit a minor to refuse life-saving treatment?
4. Critically review the circumstances under which tortious liability might attach to a registered medical practitioner who administers treatment to a patient in his care.
5. How, if at all, do ss.1-5 of the Mental Capacity Act 2005 help clarify whether a person has the capacity to consent to, or refuse, medical treatment?