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Medical Law

<u>Topic 1</u> (of 10): Consent. <u>Lecture 4</u> (of 4):

The Lawful Administration of <u>Non-Consensual</u> Medical Treatment at Common Law and Under Statute

Aim:
To examine the circumstances under which the administration of non-consensual medical treatment is: (a) legally actionable; and (b) permissible at common law and under statute.

Learning Outcomes:
After carefully reading the following notes and all other readings prescribed for this lecture, you should be able to:

1. Discuss the bases on which non-consensual medical treatment may lawfully be administered to an adult with fluctuating mental capacity and / or thought to be temporarily incapacitated and an adult who has always lacked capacity;
2. Discuss the basis on which non-consensual medical treatment may lawfully be administered to a minor;
3. Determine the identity of the person(s) authorized to make treatment decisions and / or administer treatment to those having a learning disability.

Categorising those for whom the administration of non-consensual medical treatment may be permissible.

Firstly, it's easy to ***<u>eliminate</u>*** one category of persons - *conscious adults of sound mind* - for whom the administration of non-consensual medical treatment is *<u>absolutely prohibited</u>* if legal action is to be avoided. This is because:

> "It is a civil wrong, and may be a crime, to impose medical treatment on a conscious adult of sound mind without his or her consent": *<u>In re F</u>* (*<u>Mental Patient</u>*: *<u>Sterilisation</u>*) [1990] 2 AC 1. {per ***Sir Thomas Bingham MR*** in *<u>Bland</u>* (1993)}

Indeed, conscious adults of sound mind have an unqualified right of self-determination, i.e.:

> "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; … " (*<u>Schloendorff</u>* (1914)).

For a conscious adult of sound mind, the right of self-determination exists: " … whether the reasons for making that choice are rational, irrational, unknown or even non-existent." (*per* **Lord Donaldson** in Re T (1992)). Indeed,

> "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***." (per **Prowse J**, in the Canadian case of Hopp v Lepp (1979)[1].

Respect for a patient's autonomy, or right to self-determination, has prevailed because, in moral theory: "over himself, over his own body and mind the individual is sovereign" (extracted from ***Mill's*** *Harm-to-Others theory* which he expressed in his essay On Liberty, (1854); and, at law, in the House of Lords, it has been stated that: "In modern law medical paternalism no longer rules … ", per **Lord Steyn**, Chester v Afshar [2005] 1 AC 134 @ para16.

The Legal Bases for Administering Non-Consensual Medical Treatment

(1) In respect of adults *pre*-Mental Capacity Act 2005

Prior to the coming into force of the ***Mental Capacity Act 2005***, the lawfulness of the administration of non-consensual medical treatment would be determined at common law (perhaps the majority of circumstances) or under ***Part IV*** of the ***Mental Health Act 1983***[2], for those liable to be detained in hospital under the provisions of that Act, or, in some instances, finding that the administration of such treatment did ***not*** violate provisions of the ***Human Rights Act 1998***, particularly the ***Art.3*** right, which prohibits inhuman or degrading treatment.

At common Law

With reference to a person who did not have the capacity for self-determination at the material time, e.g. someone who had been rendered temporarily unconscious as a result of an accident or someone who was and would remain permanently incompetent because of brain damage, ***Professor Michael Jones*** (University of Liverpool) had noted in his article, *Justifying Medical Treatment Without Consent*, published in Professional Negligence, that:

> "It is generally agreed that there must be some circumstances in which doctors may lawfully proceed to treat patients without their consent. ... As ***Lord Bridge*** observed in F v West Berkshire Health Authority (1989), doctors and other health care professionals would otherwise face an intolerable dilemma: if they administer

[1] See also: Re MB (An Adult: Medical Treatment) [1997] 2 FLR 426; St George's NHS Trust v S [1999] Fam 26. Under ***s.1(4) MCA 2005*** 'A person is not to be treated as unable to make a decision merely because he makes an unwise decision'.

[2] i.e., ***ss.56-64*** of the ***1983 Act*** (as amended)

> the treatment which they believe to be in the best interests of the patient they might face an action for trespass to the person, but if they withhold that treatment they could be in breach of a duty of care in negligence. The question[s], then, [are]
>
> [i] what is the legal basis for justifying what would otherwise be trespass to the person; and, more importantly,
>
> [ii] what precisely are the limits of that justification?"

The Background

In the mid-1980s, It was said that the reason why a surgeon performing an *urgent* operation on an unconscious person does not commit a battery is because: " ... the surgeon's action is acceptable in the ordinary conduct of everyday life, and [thus it is] not a battery" *per* ***Croom-Johnson LJ*** in <u>*Wilson v. Pringle*</u> (1986).

Even though this explanation appeared to be an improvement on a previous, artificial claim of an incapacitated patient being deemed to have given an *implied consent* (i.e. in cases of emergency a patient would be deemed or implied to have given his consent upon regaining consciousness), it was still claimed to be not entirely satisfactory because of the reason given by ***Lord Goff*** in <u>*Re F*</u> (1989), and summed up by ***Jones*** in *Justifying Medical Treatment Without Consent,* i.e.:

> "This dictum is open to the obvious objection that a surgeon's incision hardly falls into the same category of conduct as jostling [as experienced by commuters when catching public transport, for example] or 'back slapping' [as (say) an expression of congratulations on passing a driving test; jostling and back-slapping being regarded as 'ordinary conduct of everyday life']."

Accordingly, a more substantial criterion than 'ordinary conduct of everyday life' was required on which to base the legal justification of non-consensual treatment. What emerged was a much-criticised test that came from <u>*Re F*</u>, a 1989 House of Lords case in which their Lordships had to decide how a non-consensual sterilisation could be performed on an adult with a learning disability. The courts had no inherent jurisdiction to authorize the procedure nor did any statutory provision they examined provide the authority to perform the sterilization. However, they decided that the procedure would be lawful if it could be justified by the principle of <u>***necessity***</u> and it was in the patient's <u>***best interests***</u>. ***Lord Brandon*** said that treatment would be in the best interests of a patient:

> " ... if, but only if, it is carried out in order to either to save [her life] or to ensure improvement or prevent deterioration in [her] physical or mental health."

Jones said: "This statement of the patient's best interests is startling in its breadth". [The patient's 'best interests' were to be based on the *Bolam* test]. Moreover:

> " ... applying *Bolam* to the defence of necessity means that there may well be more than one view, or indeed several views, as to what is the best interests of the patient and, accordingly, as to what course of conduct in relation to incompetent

patients is justified in law, and *none* of these competing bodies of responsible bodies of medical opinion can be challenged in the courts. *This is medical paternalism run amok*".

Summarising the legal basis at common law for the administration of non-consensual treatment to adults

At common law, from 1989, the legal basis for the administration of emergency non-consensual medical treatment to an adult was based on ***necessity*** if it was in the patient's ***best interests*** to administer it, with the medical profession being accorded a great deal of discretion in determining 'best interests'. In England and Wales the exercise of this discretion was based on the *Bolam* standard. Confirmation of the legal basis for the administration of non-consensual medical treatment was given by the House of Lords in *Re F* (1989). (See *infra*).

N.B.: (1): Necessity ------⇒ Best Interests ------ ⇒ Bolam standard:
each stage of the process is controversial and it should be subjected to very thorough analysis. (See *infra*.)

(2): See now the qualifications on the Bolam test in *Bolitho* [1988] AC 232; *Re A* (*Medical Treatment*)(*Male Sterilisation*) [2000] 1 FCR 193; and *Re S* (*adult patient: sterilisation*) [2000] 3 WLR 1288, *infra*.

Therapeutic and Non-therapeutic Procedures; and decision-making.

If there is a distinction here then this is not an easy distinction to make. The essence of a therapeutic procedure is that it is intended to benefit a patient's health; whereas a non-therapeutic procedure may be in the *interests* of a patient without apparently benefiting his health - e.g. if it was confirmed that a child had a particular blood group and an ensuing paternity suit was successful in that adequate financial provisions were made for the child, then freedom from financial worries would appear to be in his interests even though, *prima facie,* his physical health would not be affected. (His mental health might well be improved, though! - and if psychological benefits equate with bodily health then a *non-therapeutic* procedure, the taking of a sample of blood, albeit with the consequential awarding of periodic sums of money, can benefit a patient's health: S *v. S* (1970)). That psychological benefit can outweigh physical detriment was also confirmed in *Corbett v. Corbett,* the 'sex change' case[3]. For most practical purposes, however, it would seem that necessity would be more likely to be associated with a therapeutic procedure.

A particular operation which may be thought to constitute bodily harm, but which was held to be 'therapeutic' and in the patient's best interests, related to organ donation from an incompetent person to an autonomous sibling, the procedure being 'consented' to

[3] The principle is now well-recognised in gender dysphoria and body dysmorphia cases.

initially by the incompetent's mother and confirmed by the courts. Here, the focus was not on the therapeutic / non-therapeutic distinction (if there was one) but on how the decision-making was determined: *Strunk v Strunk* (1969).

Strunk v Strunk (1969) 445 SW 2d 145

Tom S was 28 years of age, married, in employment, a part-time student and in need of a kidney transplant. His brother, Jerry, was 27, incompetent with a mental age of 6 years, a speech defect which made it difficult for him to communicate with others, and committed to a state institution for the feeble minded. Jerry was in good physical health and was found to be a suitable potential donor. The brothers' mother petitioned the court for authority to proceed with the operation.

HELD: (By a majority decision). The transplant would be authorised, as it was beneficial not only to Tom but also to Jerry because 'Jerry was greatly dependent on Tommy, emotionally and psychologically, and that his well-being would be jeopardised more severely by the loss of his brother than by the removal of a kidney'.

In *Strunk*, the consent to the transplant was based on the '***substituted judgment***' test. This has the supposed merit of attempting to ascertain the mentally incompetent person's actual preference in relation to treatment/non-treatment. As ***Rawls*** stated, we act towards the incompetent person 'as we have reason to believe [he] would choose for [himself] if [he] were [capable] of reason and deciding rationally'.

However, as stated by ***La Forest J***, in the Canadian case of *Re Eve* (1986), in relation to a woman who had been incompetent from birth: 'What the incompetent would do if she or he could make the choice is simply a matter of speculation' [i.e. it is legal fiction]. Accordingly, it is submitted that this 'test' is devoid of any merit unless the person, for whom a decision is now about to be made, had, at some time in the past, the capacity for self-determination and that he had expressed his preference should the current situation arise. Thus, as noted by ***Butler-Sloss LJ***. in *Airedale NHS Trust v Bland* (1993) it is surely more realistic for the courts to pronounce a 'substituted judgment based upon ascertaining the patient's known views, beliefs, philosophy and lifestyle ...'

(**N.B. :** (i) The difference between 'best interests' and 'substituted judgement' may be no more than a matter of 'arid semantic debate'. For example, ***Dworkin*** has indicated that, in essence, a detailed jurisprudential analysis might reveal no difference in the 'substituted judgment' approach from the 'best interests' approach. Suffice it to say that a substituted judgment test is an attempt at subjective decision-making from the particular patient's perspective – wholly inappropriate when the patient has never been competent - whilst 'best interests' is an objective test).
(**N.B.:** (ii) For the purposes of the appeal in the sterilisation case of *Re B* (1987) (see *infra*) ***Lord Hailsham*** found the distinction between therapeutic and non-therapeutic 'totally meaningless').

The criticism of the three-stage test in *Re F* for the administration of non-consensual treatment to an adult was addressed in 2000. Whereas this three-stage test still provided a good starting point, the Court of Appeal decided in *ReS* (*adult patient*: *sterilisation*) [2001] Fam 15, that as the *Bolam* test may indicate more than one possible treatment

regime, a refinement had to be made given that there can only be one definitive assessment of what constitutes the 'best interests' of the patient[4] and that is a matter for the courts, alone. Of course, where a choice exists, the least intrusive (or restrictive) alternative principle applies. Moreover, the welfare of the patient may be decided on other than purely medical grounds[5].

(2) For a 'normally' competent adult who is *temporarily* incapacitated, does the legal basis for the administration of non-consensual treatment remain rooted in 'necessity' at common law, or is it now provided for under the Mental Capacity Act 2005?

It may have appeared that administering *emergency treatment* to an unconscious adult who was admitted to hospital with no known pre-admission mentality disability has retained its legal basis in the common law doctrine of necessity rather than under the provisions of the ***MCA 2005***, given that ***s.2*(*1*)** of the Act provides that:

> For the purposes of this Act, a person lacks capacity in relation to a matter 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.

As ***Bartlett*** has noted[6]:

> "The requirement of an impairment to the mind or brain … ignores the possibility of an individual whose purely physical impairment results in incapacity. An individual without brain damage who falls unconscious following an accident, … , or is so distracted by physical pain as to be unable to meaningfully consent, could be examples where inclusion within the ambit of disorder to the 'mind or brain' might tax language to breaking point. If such individuals *were* held to be outside the provisions of the Act decisions about them would still need to be made. In the event that they are outside the MCA, *recourse to the common law might still be necessary*."

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[4] See now ***s.1*(*5*)** and **(*6*)** and ***s.4 MCA 2005***

[5] An abridged extract from the law report stated that: "*In re A* (*Medical Treatment: Male Sterilisation*) [2000] FCR 193 made it clear that the legality of treatment is determined by reference to the patient's best interests. Two different forms of treatment for the same problem cannot both be the best. Therefore, the *Bolam* test, which may be satisfied by more than one alternative, is unworkable when there is a dispute as to which of two forms of treatment should be adopted: see In re NK (unreported) 4 April 1990. [Reference was also made to *In re F* (*Mental Patient: Sterilisation*) [1990] 2 AC 1 and *Airedale NHS Trust v Bland* [1993] AC 789 .]
"The court must select that course which it believes to be in the patient's best interests, considering ethical, social, moral and welfare issues: see *In re S* (*Hospital Patient: Court's Jurisdiction*) [1995] Fam 26 . Even when exercising the declaratory jurisdiction the court's function is in practical terms the same as that of a court exercising the *parens patriae* jurisdiction: *In re G* (*Adult Patient: Publicity*) [1995] 2 FLR 528 . The best treatment is not something to be negotiated between doctors: see *Frenchay Healthcare National Health Service Trust v S* [1994] 1 WLR 601."

[6] ***Bartlett, P***. Blackstone's Guide to the Mental Capacity Act 2005, 2nd edn., 2008. Oxford: OUP, p50.

However, the better view *may* be that the legal basis for the administration of emergency non-consensual medical treatment to an unconscious road traffic accident victim ***is*** within the scope of the MCA 2005 given that ***para.4.12*** of the ***Mental Capacity Act Code of Practice*** provides that an example of an impairment or disturbance in the functioning of the mind or brain may include 'physical or mental conditions that cause *confusion*, *drowsiness* or *loss of consciousness*'[7].

Between the extremes of the temporarily incapacitated person and one who has a permanent inability to make a decision is the person with fluctuating competence. ***s.3*(*3*) *MCA 2005*** expressly provides that:

> The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

Whilst ***ss.3*(*3*)** and ***1*(*4*)** aim to protect and promote a person's autonomy as much as is practicable, they do so 'at the margins' of competence. Accordingly, in practice, it may be difficult to determine if a patient's refusal to accept treatment is a decision to be respected or overridden in his 'best interests' – but a patient's 'best interests' are to be determined by the judiciary, not the medical profession: *Re A* (*Medical Treatment*)(*Male Sterilisation*) (2000) and *Re S* (*Adult Patient: Sterilisation*) (2000).

When the need for the administration of treatment overrides Advance Directives

The lawfulness of an advance directive[8] at common law was demonstrated in *Malette v Sulman* (1990). The wish to refuse treatment of precisely the nature that arose in this case was communicated via the unsigned Jehovah's Witness card. However, if non-administration of the recommended procedure was likely to have endangered the incapacitated patient's life ***and*** to have done so in circumstances where a previous objection had ***not*** been communicated or was not a known or recognised tenet of the patient's faith; or evidence was given that the previous objection was incompatible with the patient's current circumstances, for example, an unmarried pregnant woman claiming to be a Jehovah's Witness, then the courts were likely to have declared that the medically recommended procedure was not unlawful: *Re T* (1992); and *Re MB* (1997). Indeed, in *HE v A Hospital NHS Trust* [2003] EWHC 1017 (Fam), ***Munby J*** said:

> " … once there is some real reason for doubt, then it is for those who assert the continuing validity and applicability of the advance directive to prove that it is still operative. The burden of proof is on them. … if there is doubt that doubt falls to be resolved in favour of the preservation of life … and the doctor must treat the patient in such a way as his best interests require[9] …"

[7] Hence, drunkenness ***is*** within the scope of the Act: ***paras.4.9*** and ***4.12*** of the ***Code of Practice***.

[8] Referred to as advance decisions in the MCA 2005

[9] It remains a requirement under the MCA 2005 that treatment is administered in the best interests of the

Now, under the ***MCA 2005***, where treatment has been provided in the best interests of the patient (P), P's carer (say) will not incur legal liability for the administration of such treatment – unless, of course, it was administered in contravention of ***ss.24-26 MCA 2005*** which had enabled the person now lacking capacity to have made an earlier advance directive (decision) refusing treatment.

(3) Permanently Incompetent Adult

The provisions relating to a person aged 16 or over who lacks capacity are contained in the ***Mental Capacity Act 2005***. The following provides an overview of the provisions that should be referred to prior to attempting the administration of non-consensual medical treatment:

***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* (1992)} 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 ***s.4 *for detailed discussion of best interests*}.

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.

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;

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patient: See ***s.1*(*2*) *and* (*5*);** and ***s.4 MCA 2005***.

(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.

(4) Under Mental Health Legislation: MHA 1983 (as amended)

It is well-established that a person of adult years and sound mind can refuse any, including life-saving, medical treatment and a doctor has no legal right to interfere with the patient's right of self-determination: *R v Blaue* (1975); *Malette v Shulman* (1990); *Re T* (1990); *Bland* (1993); *Re MB* (1997). However, with regard to a person who is of 'sound mind' on a fluctuating basis, i.e. someone who has lucid intervals interspersed with periods of abnormally aggressive or seriously irresponsible conduct, in other words someone who is mentally disordered within the meaning of mental disorder given in ***s.1 Mental Health Act 1983, Part IV of*** the 1983 Act contains the provisions relating to such a person's consent. In particular, there are three sections which apply to non-consensual treatment, viz;

s.58 provides for consent to treatment *or* a second opinion;
s.62 provides for treatment which is 'immediately necessary'; and
s.63 provides for treatment not requiring consent.

Part IV MHA 1983 (as amended): Consent to Treatment.

Introductory Comments

1. ***Part IV MHA 1983*** (i.e. ***ss.56-64***) applies only to *medical treatment for mental disorder* (i.e. psychiatric treatment). It relates to treatment given under the direction of the RMO [registered medical officer: the registered medical practitioner or 'doctor' in charge of the patient's clinical care]: ***s.64.*** It does ***not*** apply to treatment administered solely in order to alleviate a physical disorder (e.g. an appendectomy), or for social purposes (e.g. a non-therapeutic sterilisation).

2. Part IV '*applies to any patient liable to be detained* (*in hospital*) *under this act*' ***except*** for, *inter alia*, those who are detained for ***72*** *hours or less,* (e.g. those who are detained under the emergency admission provisions of ***s.4***, or detained under a doctor's or a nurses holding power); those remanded for report, or under guardianship or conditionally discharged. That these patients have the same 'right' to refuse treatment as any other patient was confirmed at common law in:

R v. Hallstrom, ex p L [1986] 2 All E.R. 306

Here, ***McCullough J*** said that:

There is ... no canon of construction which presumes that Parliament intended

that people should, against their will, be subjected to treatment which others, however professionally competent, perceive, however sincerely and however correctly, to be in their best interests. What there is is a canon of construction that Parliament is presumed not to enact legislation which interferes with the liberty of the subject without making it clear that this was its intention. It goes without saying that, unless clear statutory authority to the contrary exists, no one is to be detained in hospital or to undergo medical treatment or even to submit himself to medical examination without his consent. That is as true of a mentally disordered person as of anyone else.

3. The MHA 1983 establishes several categories of treatment, each with specific legal safeguards. ***s.57*** provides for treatment requiring consent ***and*** a second opinion (because of the nature of the treatment provided for) whereas ***s.58*** provides for treatment requiring ***either*** consent ***or*** a second opinion. However, both these are subject to ***s.62*** which provides for urgent treatment.

(NB.: ***s.57*** does **NOT** refer to non-consensual treatment. It is included here, however, merely to illustrate how the law relating to consent under the MHA 1983 exhibits significant departures from the general common law relating to consent. ***s.57*** applies to, *inter alia*:

> '(1)(a) any *surgical operation for destroying brain tissue or for destroying the functioning of brain tissue.*

The significance of ***s.57*** is summed up by ***Gostin*** who said of the pre-amended Act provisions:

> A ***s.57*** treatment thus requires both the patient's consent *and* a second opinion: it is virtually the only provision in English law which stipulates that, even if the patient consents, treatment *cannot* be administered unless there is *independent* verification that the patient is competent to give his consent *and* that the treatment is effective. The state therefore has the right to intervene in cases where the doctor and patient agree on the need for a medically recognised treatment.)

s. 58: Treatment requiring consent *OR* a second opinion.
The types of medical treatment requiring either consent or a second opinion are:

(1)(b) '*the administration of medicine to a patient by any means* [*subject to exclusions*] *at any time during a period for which he is liable to be detained ...* ***if three months or more*** *have elapsed since the first occasion in that period when medicine was administered to him by any means for his mental disorder*'. **(*s.58*(*1*)(*b*))**

In contrast to s.57, ***s.58*** does ***not*** apply to *informal* patients.

The three months rule.

The three months rule means that medication can be administered for three months ***without*** the consent of the patient or a second opinion. The three month period only starts when the patient concerned has been detained under a section which falls within the scope of Part IV - e.g. admission for assessment or treatment. This means that if

medication is administered to an informal patient or one who is detained ***for a period of up to 72 hours the*** *three month period does* ***not*** *come into operation.*

The aim of the three month period is to allow an accurate assessment to be made of the patient in order to decide upon the most appropriate form of treatment.

{N.B.: The three month rule does not apply to ECT. For this either consent or a second opinion is required from the outset. (s.58A**}.**

s.58A applies to ***electro-convulsive therapy*** (ECT), which also requires consent or a second opinion ***but*** "This section shall not by itself confer sufficient authority for a patient … to be given a form of treatment to which this section applies if he is not capable of understanding the nature, purpose and likely effects of the treatment (and cannot therefore consent to it)": ***s.58A*(*7*)**[10].

Gostin said of s.58 of the pre-amended Act that:

> ***s.58*** represents a fundamental departure from traditional common law assumptions in that it specifies circumstances in which treatment can be imposed upon a patient who is competent to understand the nature and purpose of the treatment, but refuses to give his consent.

s.60 provides for the possibility of a patient withdrawing his consent to treatment under s.57 or s.58 or 58A, though this is subject to ***s.62*(*2*)** which provides that treatment shall not be discontinued '... if the responsible medical officer considers that the discontinuance of the treatment ... would cause serious suffering to the patient'.

Urgent treatment

The safeguards in ss.57 & 58 do not apply in the case of urgent treatment: ***s.62*(*1*)**. Indeed, any treatment to which Part IV of the Act applies can be administered without the need for consent or a second opinion if it is urgent. Urgent treatment is that which is '**immediately necessary'** to:

1. save the patient's life; or
2. to prevent a serious deterioration of his condition; or
3. to alleviate serious suffering by the patient (excluding irreversible or hazardous treatment);
4. to prevent the patient from behaving violently or being a danger to himself or others (such treatment must be the minimum necessary to achieve this aim - irreversible or hazardous treatment is excluded).

N.B.: The essence of ***s.62*** is that it only comes into force where it is '*immediately necessary'*. The mere fact that treatment is 'necessary' or would be 'beneficial' does not mean that treatment can proceed without the need for consent and/or a second opinion. If the treatment is 'immediately necessary', and it is of the type referred to in ss.57 & 58, consent is not necessary.

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[10] ***S.58A MHA 1983*** was inserted by ***s.27*** ***MHA 2007***.

s.63 provides for treatment ***not*** requiring consent. It states that:

> The consent of a patient shall not be required for any medical treatment given to him *for the mental disorder from which he is suffering,* not being treatment falling within s.57 or 58 above, if the treatment is given by or under the direction of the responsible medical officer.

The overriding of a *competent* patient's refusal to consent enacts a Ministerial policy statement of June 1982 when it was said that:

> Failure to administer treatment would] lead us to conclude that those who were forcibly detained and had lost their liberty against their will ... should be kept in custody in places in which they received no treatment despite the fact that those who looked after them would have to gaze on them knowing perfectly well that some treatment could be given to alleviate their suffering and distress and enable them eventually to recover their liberty. Hospitals are places of treatment and we cannot have hospitals in which people are locked up and left to wander about without receiving treatment.

It has now been decided that in the case of a minor who *may be 'Gillick competent'* the Court has the right to exercise its wardship jurisdiction and override a ward's refusal to consent to treatment if it is in her best interests to do so:

In re R (a Minor) (Wardship: Medical Treatment) (1991)

A 15 year old girl had from time to time been compulsorily admitted to hospital under ss.2 and 3 MHA 1983. She refused to consent to the administration of drug therapy by injection.

HELD: R's fluctuating mental disorder prevented her from acquiring '*Gillick* competence'. Even so, a 'Gillick competent' minor who refused to accept medical treatment could be overruled by someone else who had parental rights or responsibilities including the Court exercising its wardship jurisdiction. Parental authority for the *administration* of treatment would ensure the legality of it; but in no way did it determine that the child *should* be so treated. As the Court could override parental authority then there was no reason why it could not override decisions made by '*Gillick competent*' minors.

A complaint made by a patient about treatment that was given to him under this provision (***s.63***) may be investigated by the Mental Health Act Commission.

(4A) Additional protection given to those administering non-consensual treatment by provisions of the Human Rights Act 1998

Suffice it to say that, following a ruling by the ***European Court of Human Rights*** (*HL v UK* (2005), and amendments to English law, it is the ***MCA 2005*** "that now governs the lawfulness of acts in connection with the care or treatment of incapacitated adults ***not***

covered by ***Pt IV*** of the ***1983 Act***"[11].

Where compulsory treatment is administered under the ***MHA 1983*** (as amended), if it is "convincingly shown" to be a "therapeutic necessity"[12], then it will not violate the patient's ***Art.3*** right (prohibiting inhuman and degrading treatment) nor the ***Art.8*** right to a private life.

(5) Minors

Kennedy & Grubb, in *Medical Law Text with Materials*, *2/e,* (1994) note that:

> A parent who has parental responsibility under the Children Act 1989 in respect of a child may consent to medical treatment on behalf of that child at (until majority) where the child is incompetent. Others, such as a local authority, may acquire parental responsibility under ***Part IV*** of the ***Children Act 1989*** and, thus, be empowered to consent.

This proposition is implicit in the *Gillick* case where ***Lord Scarman*** said: 'Until the child achieves the capacity to consent, the parental right to make the decision continues.'

This principle has now been extended by *Re R* (1991) and *Re W* (1992). In *Re R* (1991)*,* ***Lord Donaldson*** stated that parents could also give their consent to treatment for their '*Gillick competent*' child. The consent would not be 'determinative' in the sense that it would override the *refusal* of their Gillick competent child to undergo treatment, but it would be effective in preventing legal liability from attaching to the doctor, i.e. parental consent provides the doctor with a defence to an action in battery instituted by the minor.

Parents are under a duty to act 'in the best interests' of their child. While it is difficult to state precisely what this means, the following American case may be indicative:

Prince v Massachusetts (1944)

A Jehovah's Witness child was in need of a blood transfusion to which the parents refused their consent.

Held: ***Holmes J*** authorised it saying: 'Parents may be free to become martyrs themselves, but it does not follow that they are free in identical circumstances to make martyrs of their children before they have reached the age of full and legal discretion when they can make the choices for themselves.'

The problem, however, is the difficulty in distinguishing parental rights that are being exercised in their child's best interests from those that are 'unreasonable.' This has been illustrated by the contrasting decisions in *Re S* (*A Minor*)(*Medical Treatment*) [1993] 1 FLR 376; and *Re T* (*A Minor*) (*Wardship*: *Medical Treatment*) [1997] 1 All ER 906.

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[11] Per ***Pattinson, S.D***. *Medical Law and Ethics*, 2nd edn., 2009. London: Sweet & Maxwell, pp192-193.

[12] As expressed by the ***European Court of Human Rights*** in *Herczegfalvy v Austria* (1993).

In England, one of the most difficult decisions the Court of Appeal has ever had to make in relation to 'best interests' and minors was made in September 2000 in relation to the conjoined ('Siamese') twins born in Manchester on August 8th 2000. The Maltese parents, 'both devout Catholics' were adamant that the twin girls should not be separated and that they should be allowed to die. This would be the inevitable consequence of the weaker twin living a parasitic existence, living "on borrowed time, all of it from her sister". However, unless the separation was sanctioned, a separation that would instantly kill the weaker twin, "her parasitic living w[ould] [also] soon be the cause of [the stronger twin] ceasing to live" (per ***Ward LJ***).

The unanimous decision of the Court of Appeal was to declare that the operation to separate the twins could go ahead in order to save the life of the stronger twin as she was a "bright and alert baby, sparkling and sucking on her dummy". The decision was made on the basis of 'necessity', notwithstanding that she would still require 'major surgery to reconstruct her lower abdomen, rectum and sexual organs' ((2000) *The Times*, September 23rd), that she had between 5% and 64% chance of dying on the operating table, that the operation would involve transferring tissue from her dead 'parasitic' sister and that doubts were expressed as to whether she would be able ever to walk normally. The parents later accepted the decision.

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Appendix:

Sterilisation of Incompetent Females / Females with learning disabilities.

At common law, the legal basis of what was perhaps the most controversial procedure and which, as a consequence, has attracted a great deal of critical comment was that relating to the sterilisation of incompetent females, i.e. those with 'learning disabilities'. Here the controversy centred on the law and ethics of what some commentators saw as the deprivation of a basic human right (the right of reproduction) for non-therapeutic purposes.

Within the last twenty-five years, sterilisation of incompetent females has emerged as an issue because of the impracticality or unsuitability of other forms of contraception: 'the pill' may be an inappropriate form of contraception if the female is also taking other medication, e.g. for epilepsy. However, it is only since 1987 that a marked change in the judicial attitude towards sterilisation has become apparent.

That contraception has been considered may be due to the female in question exhibiting some degree of sexual awareness while those who have parental responsibility for her may recognise or believe that she has 'no concept of ... the consequential relationship between intercourse, pregnancy and birth' and that it may be 'disastrous for her to conceive a child'. The course of decision-making has brought about: conflict between

parents and the courts as to the meaning of what is in the incompetent's 'best interests'; academic criticisms of decided case law; and, most importantly, *perhaps* the deprivation of a basic human right to reproduction. There has been inconsistency in case law decisions.

Equally – if not more – pertinent, is that the vast majority of cases have been decided by male judges. It is a moot point whether a feminist approach to the ethics underpinning the decisions would have resulted in different decisions.

The following is a synopsis of some of the most controversial cases – but the essence relates to the dichotomy in decision-making, viz; wardship jurisdiction for minors and, 'necessity' for cases involving adults – or now, - since the coming into force of the ***MCA 2005***, cases involving adults would need to be decided in the light of its provisions, particularly ***s.4*** 'Best interests'. It's debatable whether there's a further sub-division into therapeutic and non-therapeutic procedures (but read ***Lord Hailsham's*** view in *ReB* (1987).)

Re D [1976] 1 All ER 326

D was an 11 year old girl suffering from Sotos syndrome. Sotos syndrome may include some or all of the following: accelerated growth during infancy, epilepsy, generalised clumsiness, an unusual facial appearance, behaviour problems including certain aggressive tendencies, and some impairment of mental function which could result in dull intelligence or possibly more serious mental retardation. D's mother, who was described by the judge as 'an excellent, caring and devoted mother' had requested that D be sterilised because she (the mother) recalled that in the past she lived near a family who had the misfortune to have three mentally retarded children, and their plight and their troubled lives had deeply affected her. D's mother was very worried that D might be seduced and possibly give birth to a baby, which might also be abnormal. She had always believed that D would not, or should not, marry and in any event would not be capable of bringing up a child. However, the social and behavioural reasons put forward by the consultant paediatrician for performing the sterilisation were seriously challenged by an experienced educational psychologist.
Held: ***Heilbron J*** cited with approval ***Lord Eldon's*** dicta in *Wellesley's* case that: "*It has always been the principle of this Court, not to risk the incurring of damage to children which it cannot repair, but rather to prevent the damage being done*". D remained a ward of Court because the operation was neither medically indicated nor necessary, and it would not be in D's best interests for it to be performed.

Re Eve (1986) (Decision of the Supreme Court of Canada)

Eve, who was 24 years old, attended a school for retarded adults. **'**She was attracted and attractive to men and Mrs E feared she might quite possibly and innocently become pregnant.' Mrs E was a widow approaching 60 years of age. She decided Eve should be sterilised. It was said in Court that Eve would have 'no concept of the idea of marriage, or indeed, the consequential relationship between, intercourse, pregnancy and birth'.
Held: ***La Forest J***, who also approved Lord Eldon's dicta in Wellesley's case, said: "The grave intrusion on a person's rights and the certain physical damage that ensues from

non-therapeutic sterilisation without consent, when compared to the highly questionable advantages that can result from it, have persuaded me that it can *never* safely be determined that such a procedure is for the benefit of that person. Accordingly, the procedure should *never* be authorised for non-therapeutic purposes under *parens patriae* jurisdiction."

In *Re B* (1987)***, Lord Hailsham*** found La Forest J's conclusion "totally unconvincing and in startling contradiction to the welfare principle".

Re B [1987] 2 All ER 211

Jeanette was a 17 year old girl with a mental age of five or six. Although she was described as mentally handicapped and epileptic she was exhibiting the normal sexual drive and inclinations for someone of her age. However, it was said that she would not be able to cope with birth or care for a child.

Held: The House of Lords approved the application for sterilisation. The 'basic human right' of reproduction argument was rejected. ***Lord Hailsham*** said:

> To talk of the 'basic right' to reproduce of an individual who, is not capable of knowing the causal connection between intercourse and childbirth, the nature of pregnancy, what is involved in delivery, unable to form maternal instincts or to care for a child appears ... wholly to part company with reality.

Further controversy arose from the decisions in *Re M* (1988) and *Re P* (1989).

Re M (A Minor) (Wardship: Sterilisation) (1988)

M was a 17 year old girl with a mental age of five or six. Two factors were cited as 'evidence' with regard to the sterilisation proposed for her, viz; that with the improvements in tubal surgery there was a 50 to 75% chance of successfully reversing sterilisation should M's condition ever improve; and that there was a 50% chance that any child born to M might suffer from some degree of mental retardation.

Held: The sterilisation was approved. ***Bush J*** said that the eugenic considerations (that any baby might be born with a degree of mental handicap) were irrelevant - but, (according to ***Brazier)*** he did appear to take into account evidence that if M should become pregnant an abortion on the ground of foetal handicap might be recommended.

Re P (A Minor) (Wardship: Sterilisation) (1989)

P was a 17 year old girl with a mental age of six and the communication skills of an average six year old. As she was of normal and attractive appearance, not only did her mother think she was vulnerable to seduction [apparently she had already had sexual intercourse which she described as 'painful'], but that if she became pregnant and understood what was happening she might refuse an abortion. It would be better to sterilise her than risk the trauma of separating her from her child at birth.

Held: Allowing the sterilisation, ***Eastham J*** based his decision on, *inter alia,* ***Professor Robert Winston's*** evidence that reversal of female sterilisation carried out by clips on the Fallopian Tubes now has a ***95%*** success rate!

Brazier compares this 95% success rate with " ... 50 to 75% [being] considered a good success rate by most competent gynaecologists. [And, she asks:] Can the possibility, even probability, of successful reversal justify no longer treating sterilisation as the 'last resort' but rather as a convenient method of contraception? ... "

The controversies surrounding sterilisations of incompetent females are no longer confined to minors: in 1989 the case of *Re F* attracted much criticism on the way to the House of Lords and after the opinions of their Lordships were delivered.

F v. West Berkshire Health Authority [1989] 2 All ER 545
(*in re F* [1990] 2 AC 1)

F, a 36 year old woman had been a voluntary in-patient in a mental hospital for more than 20 years. It was said that she had the verbal capacity of a child of two and the mental capacity of a child of four or five. F had formed a sexual relationship with a male patient and it was said that it would have been 'disastrous for her to conceive a child'. The psychiatric evidence to reinforce this assertion was that F would not understand the meaning of pregnancy, labour or delivery, and would be unable to care for a baby if she had one. Sterilisation was recommended as other forms of contraception were rejected for various reasons. With regard to the procedure, wardship did not apply as F was over the age of 18: there was no equivalent jurisdiction by which the court could exercise a power to consent on behalf of an incompetent adult. Nor was there jurisdiction under Part VII of the MHA 1983, 'Property and Affairs of Persons Under Disability' as the provisions were limited to business matters, legal transactions and other dealings of a similar kind.

Held: The House of Lords sanctioned the sterilisation and said that it could be justified by the principle of necessity if it was in the patient's *best interests.* ***Lord Brandon*** said that treatment would be in the best interests of a patient " ... if, but only if, it is carried out in order to either to save [her life] or to ensure improvement or prevent deterioration in [her] physical or mental health."

[***Jones*** says: "This statement of the patient's best interests is startling in its breadth]. The patient's 'best interests' are to be based on the *Bolam* test. ***Jones*** continues by noting that: " ... applying *Bolam* to the defence of necessity means that there may well be more than one view, or indeed several views, as to what is the best interests of the patient and, accordingly, as to what course of conduct in relation to incompetent patients is justified in law, and *none* of these competing bodies of responsible bodies of medical opinion can be challenged in the courts. *This is medical paternalism run amok*"].

However, it is imperative to note that not all operative procedures which result in an incompetent female being aborted and/or sterilised were based on necessity:

In re SG (Mental Patient: termination of pregnancy) [1993] 4 Med LR 75

Held: There was no requirement to seek a Court declaration for performing an abortion on a pregnant mentally handicapped woman: the ***Abortion Act 1967*** provided fully adequate safeguards for the doctors involved. (See notes on Abortion in Topic 5).

In re E (a Minor) [1991] 2 FLR 585

Held: Parents were able to give a valid consent to the proposed hysterectomy to be performed on their 17 year old mentally handicapped daughter. The operation would be carried out for therapeutic purposes and the incidental result of sterilisation did not invalidate the consent.

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Jones, *Justifying Medical Treatment Without Consent,* [1989] PN 178.

Workshop Questions

1. Answer all three parts of this question.

(a) With reference to the legal basis for non-consensual medical treatment at common law, give your reasons for preferring either the basis indicated in *Wilson v. Pringle* (1986), or that given in *Re F* (1989).

(b) If an English case virtually identical to *Strunk v. Strunk* (1969) was decided in exactly the same way, to what extent, if at all, would you welcome the decision?

(c) How, if at all, is the 'substituted judgment' test distinguished from the 'best interests' test?

2. Critically evaluate the assertion that the provisions of s.57 MHA 1983 are unnecessary and the safeguards in respect of the provisions of s.58 MHA 1983 are inadequate.

3. Critically evaluate the House of Lords decision in *Re F* [1990] 2 AC 1.

4. Critically evaluate the assertion that the administration of non-consensual medical treatment may lead to legal liability attaching to those who administer the treatment even if the treatment is successful in life-saving.

5. When, if ever, is it, or should it be, permissible to sterilise an incompetent female for non-therapeutic purposes?

6. What role, if any, remains for the *Bolam* test in deciding whether a female with learning difficulties should be sterilized?