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James Munby

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RHETORIC AND REALITY: THE LIMITATIONS OF PATIENT SELF-DETERMINATION IN CONTEMPORARY ENGLISH LAW

James Munby QC*

Anglo-American jurisprudence traditionally identifies the right of self-determination as fundamental to the principles on which our common culture and our two societies are based. English law claims to share with the law of the United States of America a commitment to the right of individuals to determine what shall be done with their own bodies. This Article seeks to explore, in the context of recent English medical-ethical case law, the extent to which the judicial rhetoric of medical self-determination is indeed matched by the law which the English courts have been developing in recent years, that is, both the law in the sense of formal rules and the law as actually applied in judicial practice.

I. LEGAL RHETORIC

It is not difficult to find in the recent English medical case law ringing declarations of the competent adult patient’s right of self-determination. Thus, in In re F, Lord Goff of Chieveley, acknowledging what he called “the libertarian principle of self-determination,” cited with approval the famous words of Justice Cardozo: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent, commits an assault.”1 So in In re T,2 Lord Donaldson of Lymington MR recognised “The patient’s . . . right to self-determination—his right to live his own life how he wishes, even if it will damage his health or lead to his premature death.” And in the same case,3 Lord Justice Butler-Sloss

* Mr. Munby is an English barrister and Queen’s Counsel who has appeared as counsel for the Official Solicitor to the Supreme Court in many of the leading medical-ethical cases in the English High Court of Justice, Court of Appeal and House of Lords. This Article retains British spelling and citation form.

2. In re T (Adult: Refusal of Treatment) [1993] Fam 95, 112E.
3. Id. at 116G.
cited with approval the judgment of Mr. Justice Robins in *Malette v Shulman*:4

The right to determine what shall be done with one’s own body is a fundamental right in our society. The concepts inherent in this right are the bedrock upon which the principles of self-determination and individual autonomy are based. Free individual choice in matters affecting this right should, in my opinion, be accorded very high priority.

The philosophical foundation for this view of the law is derived by the judges from John Stuart Mill’s *On Liberty*.5 As Mr. Justice Ward said in *Re E*:6 “The law must recognise that fundamental principle that adults of full capacity have freedom of choice. It echoes the libertarian philosophy of John Stuart Mill. It finds support in the jurisprudence both here and in the USA.”7

II. FORMAL LAW

This judicial invocation of the right of self-determination is not a mere rhetorical flourish. English law is clear and unequivocal. A competent adult patient has an absolute right to refuse consent to any medical treatment or invasive procedure, “for reasons which are rational or irrational or for no reason,” as Lord Templeman put it in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital*,8 and “even in circumstances where she is . . . certain to die in the absence of treatment.”9 The same absolute principle applies to a competent patient’s anticipatory refusal of consent. An “advance directive” or “living will” is similarly binding and effective notwithstanding that the patient has subsequently become and remains incompetent.10 If a competent adult has expressed an unequivocal decision to refuse treatment, it is not for the doctor or the court to speculate as to the strength of the patient’s personal or religious convictions or as to his reasons for refusing consent. Nor is it for the doctor or the court to speculate as to what the patient’s

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6. *Id.*
7. *Id.*
8. *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871, 904F.
Limitations of Patient Self-Determination

decision might have been if he had directed his mind to the current crisis, or if he had been more fully informed, or if he had had more forcibly brought home to him all the implications of his refusal. If it is not possible to say what the patient's decision would have been if he had been given more information: his expressed decision, if he was competent to make it, is decisive, even if it was not made in contemplation of life-threatening circumstances. Furthermore, English law emphatically rejects the doctrine that the state's interests can ever prevail over the competent patient's right of self-determination.

As is well known, case law in the United States identifies four potentially countervailing state interests: (1) the interest of the state in preserving life; (2) the interest of the state in preventing suicide; (3) the interest of the state in maintaining the integrity of the medical profession; and (4) the interest of the state in protecting innocent third parties. The first three have never been treated in English law as capable of prevailing against the individual's right of self-determination. Thus, English law asserts that the principle of self-determination prevails over the sanctity of human life. In this connection it is perhaps worth pointing out that suicide is no longer a crime in England, having been decriminalised by the Suicide Act 1961, and that in any event, as Lord Goff of Chieveley explained in *Airedale NHS Trust v Bland*, where a competent patient dies as a result of refusing treatment:

[T]here is no question of the patient having committed suicide, nor therefore of the doctor having aided or abetted him in doing so. It is simply that the patient has, as he is entitled to do, declined to consent to treatment which might or would have had the effect of prolonging his life and the doctor has, in accordance with his duty, complied with his patient's wishes.

Two recent cases illustrate this uncompromising approach. In *In re C*, a

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15. The Suicide Act 1961, 59 The Twentieth Century Statutes 160, sec. 2(1), (Eng.). This statute makes it an offence punishable by up to 14 years of imprisonment to aid, abet, counsel or procure the suicide of another person.
16. Id.
sixty-eight-year-old paranoid schizophrenic prisoner was held to be entitled to refuse consent to amputation of his gangrenous leg even though the prognosis was that he was likely to die imminently if the leg was not amputated.\textsuperscript{18} Mr. Justice Thorpe found that, despite his chronic mental illness, the patient was competent to make his own decision; and accordingly, his right of self-determination had not been displaced and would be protected by the grant of declaratory and injunctive relief.\textsuperscript{19} In Secretary of State for the Home Department v Robb, the question was whether the prison authorities were under any duty to force-feed a prisoner on a hunger strike.\textsuperscript{20} Consigning "to the archives of legal history" the much criticised decision of Lord Alverstone CJ in Leigh v Gladstone,\textsuperscript{21} a case involving the force feeding of an imprisoned suffragette, and having considered In re Caulk\textsuperscript{22} and Thor v. Superior Court,\textsuperscript{23} Mr. Justice Thorpe held that a competent adult prisoner has an absolute right to refuse food and that the authorities accordingly have neither the authority, nor, a fortiori, the duty to force-feed him if he goes on a hunger strike.\textsuperscript{24} Having considered each of the four identified countervailing state interests, Mr. Justice Thorpe said:

It seems to me that within this jurisdiction there is perhaps a stronger emphasis on the right of the individual’s self-determination when balance comes to be struck between that right and any countervailing interests of the state. So this decision is not a borderline one: this is a plain case for declaratory relief. The right of the defendant to determine his future is plain. That right is not diminished by his status as a detained prisoner. The rights of the prisoner . . . are plainly stated in Leech v Deputy Governor of Parkhurst Prison [1988] AC 533. Against the specific right of self-determination held by the defendant throughout his sentence there seems to me in this case to be no countervailing state interest to be set in the balance.

The fourth identified state interest has caused more trouble. In In re T, Lord Donaldson of Lymington MR identified as “the only possible qualification” to the absolute principle of self-determination “a case in which

\begin{itemize}
  \item \textsuperscript{18} In re C (Adult: Refusal of Treatment) [1994] 1 WLR 290.
  \item \textsuperscript{19} Id. at 295B, 296B.
  \item \textsuperscript{20} Secretary of State for the Home Department v Robb [1995] Fam 127.
  \item \textsuperscript{21} Leigh v Gladstone [1909] 26 TLR 139.
  \item \textsuperscript{22} In re Caulk, 480 A.2d 93 (N.H. 1984).
  \item \textsuperscript{23} Thor v. Superior Court, 855 P.2d 375 (Cal. 1993).
  \item \textsuperscript{24} Secretary of State for the Home Department v Robb [1995] Fam 127, 130C.
\end{itemize}
the choice may lead to the death of a viable foetus." But after initially flirting with the view that the state's interest in the protection of innocent third parties could in some circumstances justify such a procedure, it has now been held that there are no circumstances in which a nonconsensual Caesarean section can be performed on a competent woman. As Lord Justice Butler-Sloss said in Re MB:

A competent woman who has the capacity to decide may, for religious reasons, other reasons, for rational or irrational reasons or for no reason at all, choose not to have medical intervention, even though the consequence may be the death or serious handicap of the child she bears, or her own death. In that event the courts do not have the jurisdiction to declare medical intervention lawful and the question of her own best interests objectively considered, does not arise. . . . If therefore the competent mother refuses to have the medical intervention, the doctors may not lawfully do more than attempt to persuade her. If that persuasion is unsuccessful, there are no further steps towards medical intervention to be taken. . . . The only situation in which it is lawful for the doctors to intervene is if it is believed that the adult patient lacks the capacity to decide. . . . The law is, in our judgment, clear that a competent woman who has the capacity to decide may, for religious reasons, other reasons, or for no reasons at all, choose not to have medical intervention, even though . . . the consequence may be the death or serious handicap of the child she bears or her own death. . . . The court does not have the jurisdiction to declare that such medical intervention is lawful to protect the interests of the unborn child even at the point of birth.

All in all, it can now be asserted with some confidence that English law does not recognise any of the four identified state interests as capable of prevailing against the competent individual's right of self-determination.

III. LIMITATIONS TO SELF-DETERMINATION

Despite all the rhetoric, the right to self-determination is, at bottom, only a right to choose whether to give or to refuse to give consent to the treatment (or, if alternative treatments are proposed by the doctor, to

25. In re T (Adult: Refusal of Treatment) [1993] Fam 95, 102D.
one or other of the treatments) proposed by the patient’s doctor. The right to consent is merely a power to consent, not a power to compel. The patient cannot compel an unwilling doctor or health authority to provide treatment, whether that refusal is based on the doctor’s clinical or ethical judgment or on a lack of resources. In such a case, the patient’s only remedy is to find another doctor, if he can, who is prepared to give the desired treatment.

Nor is the patient any better off by seeking to invoke the assistance of the court. The court will never make an order requiring a particular doctor or health authority to treat a patient in a manner contrary to their wishes. There are two reasons for this. First, as a matter of policy, the court will never make an order compelling a doctor to treat a patient in a manner contrary to his clinical judgment and professional duty. Where the court disagrees with the views of the attending physician, the solution is to find another doctor who shares the court’s views, not to coerce the existing doctor. Second, again as a matter of policy, the court declines to answer questions relating to the resource implications of proposed treatment. The court further refuses to adjudicate in disputes between patients, doctors and health authorities arising out of the denial of treatment due to a lack of resources or the allocation of scarce resources to other patients or to other forms of treatment. This policy of judicial abdication reflects two deeply entrenched principles of the English law’s approach to public bodies. First, the statutory duties imposed upon public bodies by welfare state legislation are traditionally seen as not giving rise to any claim by an aggrieved individual justiciable in private law.

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31. In this context, the National Health Service Act 1977, replacing the National Health Service Act 1946.

Second, in the context of public law, judicial control, by the mechanism of judicial review, is confined to three grounds: illegality, procedural impropriety or irrationality, the latter being confined to what Lord Diplock in *Council of Civil Service Unions v Minister for the Civil Service* described as “a decision which is so outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question to be decided could have arrived at it.”

Medical treatment issues naturally will not involve any issue of either illegality or procedural impropriety, as those terms are understood in English law, and the test of “irrationality” is so stringent as to be almost impossible to meet. This is particularly the case where the decision relates to the prioritisation or allocation of scarce resources, whether human or financial, matters which the judges treat in practice, if not in theory, as being nonjusticiable.

Lord Donaldson of Lymington MR summarized the issue well in two cases. Each involved the exercise of the inherent *parens patriae* jurisdiction over children, but the point is *a fortiori* in the case of a competent adult. First, in *In re J,* Lord Donaldson stated:

> No one can dictate the treatment to be given to the child—neither court, parents nor doctors. There are checks and balances. The doctors can recommend treatment A in preference to treatment B. They can also refuse to adopt treatment C on the grounds that it is medically contra-indicated or for some other reason is a treatment which they could not conscientiously administer. The court or parents for their part can refuse consent to treatment A or B or both, but cannot insist upon treatment C. The inevitable and desirable result is that choice of treatment is in some measure a joint decision of the doctors and the court or parents. This co-operation is reinforced by another consideration. Doctors nowadays recognise that their function is not a limited technical one of repairing or servicing a body. They are treating people in a real life context. This at once enhances the contribution which the court or parents can make towards reaching the best possible decision in all the circumstances. Finally mention should be made of one problem to the solution of which neither court nor parents can make any contribution. In an imperfect world resources will always be limited and on occasion agonising choices will have to be made in allocating those

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33. *Council of Civil Service Unions v Minister for the Civil Service* [1985] AC 374, 410G.
resources to particular patients. It is outwith the scope of this judgment to give any guidance as to the circumstances which should determine such an allocation. . . . neither the court in wardship proceedings, nor, I think, a local authority having care and control of the baby is able to require the [health] authority to follow a particular course of treatment. What the court can do is to withhold consent to treatment of which it disapproves and it can express its approval of other treatment proposed by the authority and its doctors.35

Secondly, in In re W, Lord Donaldson stated:

There seems to be some confusion in the minds of some as to the purpose of seeking consent from a patient (whether adult or child) or from someone with authority to give that consent on behalf of the patient. It has two purposes, the one clinical and the other legal. The clinical purpose stems from the fact that in many instances the co-operation of the patient and the patient's faith or at least confidence in the efficacy of the treatment is a major factor contributing to the treatment's success. Failure to obtain such consent will not only deprive the patient and the medical staff of this advantage, but will usually make it much more difficult to administer the treatment. I appreciate that this purpose may not be served if consent is given on behalf of, rather than by, the patient. However, in the case of young children knowledge of the fact that the parent has consented may help. The legal purpose is quite different. It is to provide those concerned in the treatment with a defence to a criminal charge of assault or battery or a civil claim for damages for trespass to the person. It does not, however, provide them with any defence to a claim that they negligently advised a particular treatment or negligently carried it out.36

Thus, in Hohfeldian terms, when treating "right" as the correlative of "duty,"37 the "right of self-determination" is a misnomer. There is no right to determine what shall be done to one's own body; there is only a right to determine what shall not be done to one's body.

IV. LEGAL REALITY

In practice, and even within the sphere in which in theory it is free to
operate, the so-called right of self-determination tends to be cramped in
two ways. Genuine adherence to the principle of self-determination re-
quires, first, that competent patients are given sufficient information to
give them the option of reaching an informed choice. Second, it requires
that their decisions are respected, even if when judged from the “ra-
tional” perspective of the doctor or judge, whose decisions may seem un-
wise, unreasonable or even irrational. English law has difficulty
accommodating itself to either of these precepts. In the first place, there
is a tendency to downplay the amount of information that patients re-
quire or are entitled to receive. In the second place, and more insidi-
ously, there is a tendency to impose an unrealistically stringent test of
capacity, particularly in those cases where patients are judged to be un-
reasonably refusing life-saving treatment. In short, English law in practice
tends to “talk down” the patient’s need for information, while at the same
time paradoxically tending to “talk up” the patient’s need for capacity.
The practical effect in both cases is to weigh the balance against the pa-
tient in favour of the doctor. The competent patient is expected to come
to a decision on the basis of such information as the doctor thinks it ap-
propriate to give. The patient whose decision in a potentially life-threat-
ening situation is felt to be unwise, unreasonable or worse, may find
himself—more usually, herself—categorised by the doctor and the court
as incompetent; and consequently38 subjected to the treatment that the
doctor, or the court, feels, or chooses to assert, is the patient’s best
interests.

To return to Hohfeldian analysis, the patient’s “immunity” and the doc-
tor’s correlative “disability,”39 both of which are implicated in the so-
called “right of self-determination,” are in practice far less absolute than
either rhetoric or formal legal rules would suggest.

The adverse consequences for the patient are exacerbated by two fur-
ther characteristics of the typical English judicial approach to such cases.
First, the courts fail to articulate, let alone enforce, appropriate proce-
dural and substantive safeguards for the patient whose consent is sought
to be dispensed with. Second, the courts fail,40 and in some cases re-
fuse,41 to articulate what is meant by a patient’s “best interests.” The fail-
ure of the House of Lords to formulate either procedural or substantive

38. In re F (Mental Patient: Sterilisation) [1990] 2 AC 1, 51G, 56D, 71H-77D.
39. Hohfeld, supra note 37, at 36, 60-63.
40. For an egregious and much criticised example of such failure, see In re B (A Mi-
41. In re J (A Minor) (Wardship: Medical Treatment) [1991] Fam 33, 52D (per
safeguards for children\textsuperscript{42} and incompetent adults\textsuperscript{43} in cases of nontherapeutic sterilisations compelled the Official Solicitor to the Supreme Court to publish appropriate guidelines in a Practice Note.\textsuperscript{44} And only very recently have the courts sought to formulate these safeguards for cases where the patient’s capacity is or may be in issue,\textsuperscript{45} or where the court is being invited to sanction coercive treatment methods.\textsuperscript{46}

V. Consent

English law does not recognise the doctrines of “informed consent” or “informed refusal of consent” in the sense in which those terms are used in North America.\textsuperscript{47} This has two consequences. First, so far as concerns the law of trespass, the only question is whether the patient knew in broad terms the nature and effect of the procedure to which he was giving or refusing consent.\textsuperscript{48} This is not a particularly stringent test. The law of trespass accordingly does little to assist the patient in obtaining enough information to make real the right of self-determination. Moreover, there is judicial opposition to the use of trespass as a means of enforcing appropriate standards of medical behaviour. That view has been forcibly expressed that in general, the proper cause of action, if any, is negligence and not trespass.\textsuperscript{49}

Second, the law of negligence does little to compel disclosure by the doctor to his patient of relevant information. The “Bolam” test\textsuperscript{50} of pro-

\begin{itemize}
\item Balcombe LJ; In re T (A Minor) (Wardship: Medical Treatment) [1997] 1 WLR 242, 254F (per Waite LJ).
\item In re B (A Minor) (Wardship: Sterilisation) [1988] AC 199.
\item In re F (Mental Patient: Sterilisation) [1990] 2 AC 1.
\item Practice Note (Official Solicitor: Sterilisation) [1989] 2 FLR 447. The current revised text is Practice Note (Official Solicitor: Sterilisation) [1996] 2 FLR 111. The Official Solicitor has also issued a Practice Note in relation to PVS cases: Practice Note (Official Solicitor: Persistent Vegetative State) [1996] 2 FLR 375 replacing earlier text in [1994] 1 FLR 654.
\item Re MB (Medical Treatment) [1997] 2 FLR 426, 436G-437H, 439D, 445A-G.
\item Re C (Detention: Medical Treatment) [1997] 2 FLR 180, 196H-201F; Re MB (Medical Treatment) [1997] 2 FLR 426, 445A-G.
\item Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] AC 871; In re T (Adult: Refusal of Treatment) [1993] Fam 95, 115B.
\item Bolam v Friern Hospital Management Committee [1957] 1 WLR 582.
\end{itemize}
fessional negligence applies as much to the advice that a doctor gives to his patient, including any warnings he ought to give, as to his functions of diagnosis and treatment.\textsuperscript{51} A doctor falls foul of the "Bolam" test only if he is guilty of such failure as no doctor of ordinary skill would be guilty if acting with ordinary care.\textsuperscript{52} That is a difficult test for any plaintiff to establis

Where there is room for differences of medical opinion and practice, a doctor who follows an acceptable school of thought is not negligent, even if there is another school of thought that considers his decision to have been wrong.\textsuperscript{53}

In short, subject to compliance with the minimum disclosure requirements imposed by the law of trespass, patients are generally required to receive only such information in arriving at treatment decisions as the medical profession thinks appropriate.

VI. CAPACITY

An adult is presumed to have mental capacity.\textsuperscript{54} Therefore, the burden of proof is on those who seek to rebut the presumption and to assert a lack of capacity. In relation to medical treatment, the question is whether the patient is "competent to appreciate the issues involved"\textsuperscript{55} so as to be able to exercise a "right of choice,"\textsuperscript{56} and whether he sufficiently "understand[s] the nature, purpose and effects of the treatment."\textsuperscript{57} Fundamentally, the question is whether the patient has the ability, whether or not actually exercised, to function rationally. This involves three questions:\textsuperscript{58} (1) Can the patient take in, comprehend and retain treatment information? (2) Does he believe that information? and (3) Can he weigh the

\textsuperscript{51} Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] AC 871.


\textsuperscript{53} Maynard v West Midlands Regional Health Authority [1984] 1 WLR 634, 638E-H, 639F. \textit{But see} the qualification in Bolitho v City and Hackney Health Authority [1997] 3 WLR 1151.


\textsuperscript{55} In re F (Mental Patient: Sterilisation) [1990] 2 AC 1, 12D per Lord Donaldson of Lymington MR.

\textsuperscript{56} \textit{Id.} at 31A, 34B per Neill and Butler-Sloss LJ.

\textsuperscript{57} In re C (Adult: Refusal of Treatment) [1994] 1 WLR 290, 295C, 295E per Thorpe J.

\textsuperscript{58} \textit{Id.} at 292E, 295C-F.
information in the balance so as to arrive at a choice? It is not necessary for the patient to understand everything about a complicated decision, so long as he can understand the essentials if explained to him in broad terms and simple language.\textsuperscript{59}

As a matter of principle, this is all entirely unobjectionable. But in practice, it is not too difficult to find that a patient who is unreasonably refusing treatment, in particular life-saving treatment, lacks capacity. In that situation, the doctor is freed from the patient's refusal of consent and the doctor\textsuperscript{60} is enabled to act in what he conceives to be the patient's best interests.

It has been said that the degree of capacity required varies with the circumstances of the particular treatment—it must be commensurate with the gravity of the decision,\textsuperscript{61} for "the more serious the decision, the greater the capacity required."\textsuperscript{62} A high degree of capacity is required to refuse life-saving treatment.\textsuperscript{63}

In deciding whether a patient has capacity, the doctor and the court must consider whether, and if so to what extent, the patient's normal capacity may have been temporarily reduced by the effects of injury, illness, drugs, confusion, shock, pain, anxiety, depression, fatigue or panic induced by fear, among other factors.\textsuperscript{64} In evaluating the evidence, it is easy for the court to overemphasise these factors. Moreover, and particularly in such circumstances, it is easy for a judge, while accepting that a patient is able to take in, comprehend and retain treatment information, and that he does believe that information, nonetheless to find that the patient lacks the capacity to weigh the information in the balance. Taking these two factors together, it is not too difficult if one is so minded, and some judges in some circumstances appear to be more than willing, to find that an otherwise normally competent patient is temporarily incompetent to refuse consent to treatment.

The combination of these two approaches, some might say devices, has enabled judges in a succession of controversial cases to hold that otherwise competent pregnant women in the final stages of delivery lack the

\textsuperscript{59} Cambridgeshire County Council v R (An Adult) [1995] 1 FLR 50, 54A.
\textsuperscript{60} In re F (Mental Patient: Sterilisation) [1990] 2 AC 1, 51G, 56D, 71H-77D.
\textsuperscript{61} Re MB (Medical Treatment) [1997] 2 FLR 426, 437C.
\textsuperscript{62} In re T (Adult: Refusal of Treatment) [1993] Fam 95, 113B, 116B \textit{per} Lord Donaldson of Lymington MR.
\textsuperscript{63} Cf Re E (A Minor) (Wardship: Medical Treatment) [1993] 1 FLR 386, 391A-F.
\textsuperscript{64} In re T (Adult: Refusal of Treatment) [1993] Fam 95, 111E-H, 113A-E, 113H, 115G, 118B, 122B; Re MB (Medical Treatment) [1997] 2 FLR 426, 437C, 437G.
capacity to refuse consent to the Caesarean section, which both the judges and the attending doctors believe to be in their best interests. Likewise in In re T, the refusal of a woman in labour to consent to a blood transfusion was overridden on the ground that her medical condition rendered her unfit at the time to make a genuine decision.

VII. The Mental Health Act 1983

The same result can be, and is, achieved by recourse to statutory powers. Persons suffering from "mental disorder" are liable to be compulsorily detained in accordance with the Mental Health Act 1983. In relation to such persons, section sixty-three of the Act provides, subject to certain limited exceptions: "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 . . . if the treatment is given by or under the direction of the responsible medical officer."

"Medical treatment" in section sixty-three means treatment, which taken as a whole is calculated to alleviate or prevent a deterioration of the mental disorder from which the patient is suffering and includes a range of acts ancillary to the core treatment, including those that prevent the patient from harming himself or which alleviate the symptoms of the disorder. "[R]elieving symptoms is just as much a part of treatment as relieving the underlying cause."

Again, there is nothing objectionable in principle to such a regime. But judicial creativity has seen interpretations of section sixty-three that some might find, at first sight, rather surprising. Thus, "medical treatment" in


67. The willingness of judges to hold otherwise competent pregnant women incompetent when (query, because) they are in the final stages of labour can be contrasted with the judicial willingness to give effect to the equally life-threatening decisions of the male prisoners in In re C (Adult: Refusal of Treatment) [1994] 1 WLR 290 and Secretary of State for the Home Department v Robb [1995] Fam 127.

68. Defined in section 1(2) of the Act as meaning "mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind."


70. Re KB (Adult) (Mental Patient: Medical Treatment) (1994) 19 BMLR 144, 146 per Ewbank J approved B v Croydon Health Authority [1995] Fam 133, 139F, 141C.
section sixty-three has been held to include forcible feeding for the treat-
ment of anorexia nervosa71 or other psychiatric illnesses.72 More contro-
versially, it has been held to include inducing labour and performing a
Caesarean section on a pregnant paranoid schizophrenic where effective
treatment of the schizophrenia required that the patient give birth to a
live baby and resume medication necessarily interrupted by her preg-
nancy, including, if necessary, restraint and the use of reasonable force.73

Concern has been expressed that there is little to prevent the doctor
faced with an uncooperative pregnant woman who, judged from the doc-
tor's perspective, is acting unreasonably, from arranging to have the wo-
man “sectioned” temporarily74 simply for the purpose of enabling a
Caesarean section to be performed on her without her consent in accord-
ance with section sixty-three. The propriety of such a course has not yet
been judicially considered. At least some of the issues may shortly have
to be considered in Re S's Application for Judicial Review,75 in which the
Court of Appeal granted a pregnant woman who was “sectioned” under
the Act and thereafter subjected to a nonconsensual Caesarean section
leave to apply for a judicial review of the various decisions.

VIII. ADVANCE DIRECTIVES

Where the obstacle in the doctor's way is the existence of an apparent
“advance directive,” the court can be equally astute to find reasons for
deciding to give effect to it.

In the first place, there is a curious and highly significant reversal of the
burden of proof. As we have seen, the burden of proof of self-determi-
nation is on those who seek to rebut the presumption of adult capacity and
to assert a lack of capacity. However, with advance directives, the burden
of proof is on those who seek to establish an advance directive that re-
fuses life-saving treatment or life-sustaining artificial feeding. If there is
doubt, “that doubt falls to be resolved in favour of the preservation of

71. Riverside Mental Health NHS Trust v Fox [1994] 1 FLR 614; Re KB (Adult)
(Mental Patient: Medical Treatment) (1994) 19 BMLR 144; B v Croydon Health Authority
73. Tameside and Glossop Acute Services Trust v CH [1996] 1 FLR 762, 771c-774C.
74. This means compulsorily detained in accordance with the Mental Health Act 1983.
This process does not require prior judicial authorisation.
76. In re T (Adult: Refusal of Treatment) [1993] Fam 95, 112F per Lord Donaldson of Lymington MR.
77. Id. at 102G, 103C, 112F; Airedale NHS Trust v Bland [1993] AC 789, 864F.
79. In re C (Adult: Refusal of Treatment) [1994] 1 WLR 290, 295F.
83. Adopting In re Conroy, 486 A.2d 1209, 1230, 1232 (N.J. 1985); In re Jobes, 529

life.” The evidence must be scrutinised with “especial care.” Thus, although there are no formal requirements for a valid advance directive, which need not be in, or evidenced by, writing, and may be proved by a single witness deposing to a conversation with the patient on a single occasion, and although there is no requirement of corroboration, the advance directive must be “clearly established,” not speculative and expressed “in clear terms.” English law thus corresponds to the “specific-subjective-intent rule” applied in the United States by the New York and Missouri courts, which requires “clear and convincing, inherently reliable evidence.”

There are six matters which have to be proved in order to establish an advance directive that is binding and effective in relation to an adult incompetent: (1) that at the date of the advance directive the patient was of sound mind (i.e., competent, as discussed earlier); (2) that the patient had the capacity to make not merely a present but also an anticipatory decision, that is, the capacity to weigh the consequences of future hypothetical circumstances; (3) that the patient knew in broad terms the nature and effect of the procedure to which he was giving or refusing consent; (4) that the patient’s decision was (i) voluntary and unequivocal, (ii) “real” and not “expressed in form only” and (iii) free of vitiating influences (e.g., coercion or undue influence, the withholding of relevant information, misinformation or mistake); (5) that the patient’s decision was made with reference to and was intended to cover the particular (and perhaps changed or unforeseen) circumstances which have in fact subsequently occurred; and (6) that the patient’s expressed views represented a carefully considered position rather than “informally expressed reactions to other people’s medical condition and treatment” or “an offhand remark about not wanting to live under certain circumstances made by a person when young and in the peak of health.”
Again, it is difficult to fault this approach as a matter of formal law. But in practice it is not too difficult to upset anything other than the most carefully drawn and unequivocally expressed written advance directive. Thus, applying these principles, the court in In re T\textsuperscript{84} refused to find that there had been a valid and effective advance directive, even though the patient had signed a refusal of consent to blood transfusions, on the ground that she was not fit, because of her medical condition, to make a genuine decision.\textsuperscript{85}

IX. Judicial Attitudes to Self-Determination

Other examples of the prevailing judicial reluctance to endorse wholeheartedly the reality rather than the mere rhetoric of medical self-determination are not difficult to discern. Three will suffice for present purposes.

The first example relates to competent patients. It might be thought that for a doctor to proceed in defiance of his competent patient’s known refusal of consent would be treated as a serious infringement of the patient’s fundamental human rights, calling for an award of substantial damages. This was the view of the Canadian judges in Malette v Shulman, where the life of a Jehovah’s Witness had been saved by a blood transfusion carried out contrary to her known wishes and substantial damages were awarded for mental distress.\textsuperscript{86} This approach does not find favour in England. In In re T, Butler-Sloss and Staughton LJJ questioned whether an English court would award such substantial damages in the given circumstances.\textsuperscript{87}

The second example relates to mature teenage children. The custodial power that enables a parent to exercise physical control over the person of the child, which is most relevant in the context of medical treatment, necessarily comes to an end with the child’s majority at the age of eighteen. But it ceases in any event when the child reaches “the years of discretion.”\textsuperscript{88} When the child achieves a sufficient understanding and intelligence to enable him to comprehend fully what is proposed, he has the capacity to give a valid consent to medical treatment. The conven-

\textsuperscript{84} In re T (Adult: Refusal of Treatment) [1993] Fam 95.
\textsuperscript{85} Id.
\textsuperscript{87} In re T (Adult: Refusal of Treatment) [1993] Fam 95, 117B, 122D.
\textsuperscript{88} Hewer v Bryant [1970] 1 QB 357, 372B-373D.
tional shorthand is to refer to such a child as having “Gillick capacity” or as being “Gillick competent.” The key to “Gillick competence” is the child’s understanding and intelligence. In determining whether a particular child is “Gillick competent” in relation to a particular proposed treatment, what is examined is the capacity to reach a mature and balanced judgment: “the attainment by a child of an age of sufficient discretion to enable him or her to exercise a wise choice in his or her own interests.”

Thus, as Lord Scarman said in *Gillick v West Norfolk and Wisbech Area Health Authority*:

I would hold that 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 a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law.

Some of the factors to be taken into account are the child’s understanding and intelligence; his chronological, mental and emotional age; his intellectual development and maturity and capacity to make up his own mind; his ability to understand fully, and to appraise, the medical advice being given, as well as the nature, consequences and implications of the advised treatment; his capacity to comprehend the potential risks to his health, and the emotional impact of either accepting or rejecting the advised treatment; and finally, his capability to understand any moral and family questions involved.

Furthermore, once the child reaches the age of sixteen, section 8(1) of the Family Law Reform Act 1969 comes into play. It provides:

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 by virtue of this section given an effective consent to

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89. *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, 169A-F, 171E, 186D, 188H-189D, 195A, 201A; In re W (A Minor) (Medical Treatment: Court’s Jurisdiction) [1993] Fam 64, 81F.

90. *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, 188A per Lord Scarman.

91. *Id.* at 188H.

92. *Id.* at 174D, 189A-E, 190A, 201A-C; In re R (A Minor) (Wardship: Consent to Treatment) [1992] Fam 11, 26A.
any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.

It might be considered obvious that a sixteen- or seventeen-year-old child, or a child who has not yet reached the age of sixteen but who is "Gillick competent," would be treated as being free from parental decision making, and that such a child would thus be as entitled as an adult to exercise the right of self-determination. Yet this is not the case.

In the first place, judges when faced with fractious teenagers are astute enough to find that they lack capacity. Thus, fifteen-year-old Jehovah's Witnesses refusing blood transfusions were held not to be "Gillick competent" in *Re E* and *Re S*. In applying the test enunciated in *In re C*, a sixteen-year-old anorexic was held not to be competent to refuse treatment in *Re C*.

More surprisingly, and most controversially, it has been held that, although a "Gillick competent" child's consent to treatment is as valid and effective as the consent of a competent adult, a parent can lawfully consent to the treatment of a "Gillick competent" child who is refusing to consent. Thus, while a parent cannot overrule a "Gillick competent" child's consent to treatment, a parent can, in effect, overrule a "Gillick competent" child's refusal to consent to treatment: the parent and the child have concurrent powers to consent and, so it has been said, where more than one person has a power of consent, only a failure to, or refusal of, consent by all creates a veto. Nor is the court bound by the wishes or decision of a "Gillick competent" child. Thus, the court, if it chooses to exercise its inherent powers, can always outflank what might appear to be the perfectly clear legislative policy laid down in the Children Act 1989 and do the very things which the Act has said that it shall not do.

101. As in *South Glamorgan County Council v W and B* [1993] 1 FLR 574 (order under inherent jurisdiction for psychiatric examination and assessment of "Gillick competent" child who had validly refused consent under Children Act 1989, section 38(6)).
Perhaps even more surprisingly, and notwithstanding section 8(1) of the 1969 Act, it has been held that in the case of a sixteen- or seventeen-year-old child, as in the case of a “Gillick competent” child, while a parent cannot overrule the child’s consent to treatment, the parent can, in effect, overrule such a child’s refusal to consent to treatment. Likewise, notwithstanding section 8(1), the court in the exercise of its inherent parens patriae jurisdiction is not bound by the wishes of a sixteen- or seventeen-year-old child. This view of the law has been the subject of severe academic criticism, as involving an inappropriately narrow construction of the language of section 8(1) of the Family Law Reform Act 1959, which had previously been considered as conferring “complete autonomy” on the sixteen- or seventeen-year-old child.

This English view of what might be described as the autonomous child’s severely restricted autonomy has not found favour either in Canada or even in Scotland, where the competent child is treated as being precisely that, an autonomous individual not subject to either parental or judicial intervention. As Sheriff McGowan said in Re Houston:

> It seems to me illogical that, on the one hand a person under the age of 16 should be granted the power to decide upon medical treatment for himself while, on the other hand, his parents have the right to override his decision . . . logic demands that the minor’s decision is paramount.

The final example relates to incompetent adults. With respect to concerns about an incompetent adult’s property and affairs, the English court applies, and has always applied, a subjective substituted judgment test. The principle is an old one, going back to Ex p Whitbread. Some jurisdictions in the United States have extended the substituted judgment test;

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105. Re Houston (1996) 32 BMLR 93 (declining to follow the English authorities).

106. In Scotland, the matter is regulated by the Age of Legal Capacity (Scotland) Act 1991, section 2(4), which in effect introduces in Scotland a statutory equivalent of the English common law test of “Gillick competence.”


108. In re D (J) [1982] Ch 237, 244C per Megarry VC (“[the] court must seek to [do that] which the actual patient, acting reasonably, would have [done] if notionally restored to full mental capacity, memory and foresight”).

sometimes by explicitly adopting the English property cases and, in particular, *Ex p Whitbread* to questions relating to the patient's body.\textsuperscript{110} However, English law, in common with a number of other jurisdictions in the United States, which also apply a best interests test,\textsuperscript{111} has rejected the subjective substituted judgment test regarding questions about the patient's physical and bodily welfare in favour of an objective best interests test.\textsuperscript{112} The reason for the divergence in English law between the objective test applied in cases affecting the person of the incompetent and the subjective substituted judgment test applied in cases relating to his property has never been explained or explored. Again, however, it is indicative of the reluctance of English judges to allow the patient to have as much control as possible over his body.


\textsuperscript{111} In re Richardson, 284 So. 2d 185, 187 (La. 1973); Lausier v. Pescinski, 226 N.W.2d 180-82, 184 (Wis. 1975); Little v. Little, 576 S.W.2d 493, 497-98 (Tex. 1979); Curran v. Bosze, 566 N.E.2d 1319, 1326, 1331 (Ill. 1990).

\textsuperscript{112} Airedale NHS Trust v Bland [1993] AC 789, 871G-872E, 894G-895D.